C+D
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24/31 July 2010

Boots boss: 'Double digit growth is our mantra'

EXCLUSIVE Stefano Pessina reveals the ethos behind the UK's biggest pharmacy chain page 4

CPD ZONE

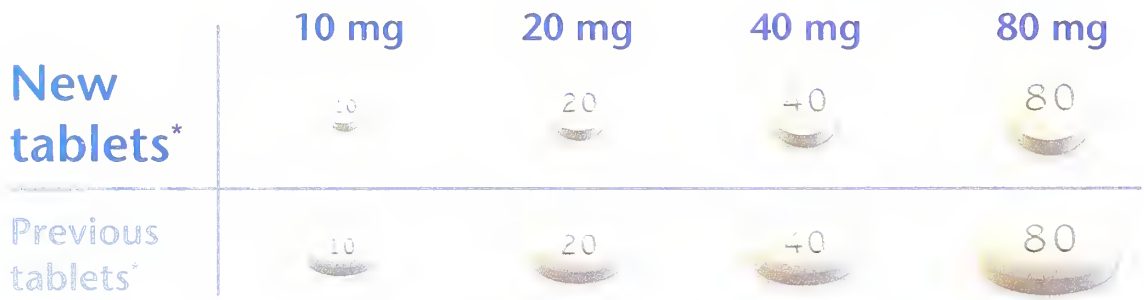
Introducing Lipitor in a smaller size

Same Lipitor.
Same cardiovascular benefits.[1]

Lipitor is now available in a smaller size. The size and shape of the tablets are new, and the cardiovascular benefits[1] remain the same. The 80 mg pack in particular is much smaller.

Reassure your patients that their treatment will offer the same cardiovascular risk reduction[1] as always.

†Not actual size.



*Actual size.

LIPITOR atorvastatin

Abbreviated prescribing information: Lipitor®
Presentation: Lipitor is supplied as film-coated tablets containing 10mg, 20mg, 40mg or 80mg of atorvastatin.
Indications: In patients unresponsive to diet and other non-pharmacological measures, Lipitor is indicated for the reduction of elevated total cholesterol, LDL-cholesterol, apolipoprotein B, and triglycerides in adults and children aged 10 years and older with primary hypercholesterolaemia, heterozygous familial hypercholesterolaemia or combined (mixed) hyperlipidaemia. Lipitor also raises HDL-cholesterol and lowers the LDL/HDL and total cholesterol/HDL ratios. Lipitor is also indicated for the reduction of elevated total cholesterol, LDL-cholesterol, and apolipoprotein B in patients with homozygous familial hypercholesterolaemia. Lipitor is indicated for reducing the risk of cardiovascular events in patients with Type II diabetes and one additional risk factor, without clinically evident coronary heart disease, irrespective of whether cholesterol is raised.
Dosage: The usual starting dose is one Lipitor 10mg tablet daily. Doses should be individualised according to baseline LDL-C levels, the goal of therapy, and patient response. Doses may be given at any time of the day with or without food. The maximum daily dose is 80mg. For patients taking drugs that increase plasma exposure to atorvastatin the starting dose should not exceed 10 mg and maximum dose of less than 80 mg may have to be considered. Doses above 20mg/day have not been investigated in patients aged <18 years. In primary prevention trials, the dose was 10mg/day.
Contraindications: Hypersensitivity to any of the ingredients, active liver disease, unexplained elevations in serum transaminases, pregnancy and breast-feeding and in women of child-bearing potential not using contraception.
Warning and precautions: Liver function tests should be performed before initiation and periodically thereafter and in patients who show signs and symptoms of liver injury (monitor raised transaminases until they return to normal). Drug dosage should be reduced or therapy discontinued if persistent elevations occur above 3-times the upper limit of normal. Lipitor should be used with caution in patients with a history of liver disease and/or alcoholism. For patients with prior haemorrhagic stroke or lacunar infarct, the balance of risks and benefits of atorvastatin 80 mg is uncertain and the potential risk of haemorrhagic stroke should be carefully considered before initiating treatment. Patients with signs and symptoms of myopathy should have their creatine phosphokinase (CPK) levels monitored. Lipitor should be discontinued if CPK levels are markedly or persistently raised or myopathy is diagnosed or suspected. Lipitor should be prescribed with caution in patients with pre-disposing factors for rhabdomyolysis. Risk of myopathy may increase when administered with certain medications that increase the plasma concentration of atorvastatin. If co-administration is required a dose reduction or if not practical a temporary suspension should be considered; the starting dose of atorvastatin should be 10 mg. In the case of ciclosporin, clarithromycin and itraconazole a lower maximum dose should be used. Although interaction studies with atorvastatin and fusidic acid have not been conducted, severe muscle problems such as rhabdomyolysis have been reported in post-marketing experience with this combination – therefore patients should be closely monitored and temporary suspension of atorvastatin treatment may be appropriate. As with other statins, rhabdomyolysis with acute renal failure has been reported. A history of renal impairment may be a risk factor for rhabdomyolysis. Exceptional cases of interstitial lung disease have been reported with some statins and statin therapy should be discontinued if a patient is suspected to have developed interstitial lung disease. Patients with galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption should not take this product.
Pregnancy and lactation: Lipitor is contraindicated in pregnancy and lactation.
Side effects: Side effects most frequently reported in controlled clinical studies: nasopharyngitis, hyperglycaemia, pharyngolaryngeal pain, epistaxis, constipation, flatulence, dyspepsia, abdominal pain, headache, nausea, arthralgia, myalgia, pain in extremity, musculoskeletal pain, muscle spasms, joint swelling, asthenia, diarrhoea, insomnia, abnormal liver function tests, elevations in ALT and CPK levels. Other side effects have been reported in clinical trials and post-marketing (See Summary of Product Characteristics).
Legal category: POM.
Date of Revision: December 2009
Package quantities, marketing authorisation numbers and basic NHS price: Lipitor 10mg (28 tablets), PL16051/0001 £13.00, Lipitor 20mg (28 tablets), PL16051/0002 £24.64, Lipitor 40mg (28 tablets) PL16051/0003 £24.64, Lipitor 80mg (28 tablets) PL 16051/0005 £28.21.
Marketing Authorisation Holder: Pfizer Ireland Pharmaceuticals, Pottery Road, Dun Laoghaire, Co. Dublin, Ireland.
Lipitor is a registered trade mark.
Further information is available on request from: Medical Information, Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS.
Ref: LR 12_1.

Reference: 1. Colhoun HM *et al. Lancet* 2004; 364: 685-696.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk Adverse events should also be reported to Pfizer Medical Information on 01304 616161.

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> IT'S ALLIANCE BOOTS' SHEER BREADTH OF ACTIVITY ACROSS THE UK'S PHARMACEUTICAL SECTOR THAT PUTS IT AT THE TOP OF THE FOOD CHAIN

If C+D ran a Pharmacy Power Survey (now there's an idea), who would you vote for as the most powerful individual in community pharmacy?

Would it be the government's health secretary Andrew Lansley – a man who defines the future direction and remuneration of our sector? Perhaps it's the contract negotiators PSNC or CPS. After all, they are charged with negotiating the framework under which the sector works and the remuneration structure that supports it.

Arguably, it's none of the above – it is Stefano Pessina, the nuclear engineer who, after turning the family business into Italy's leading pharmaceutical wholesaler, has ended up at the helm of the international pharmacy giant Alliance Boots.

Putting aside the fact that the company founded by John and Mary Boot 160 years ago now operates in over 20 countries, it's the business's sheer breadth of activity across the UK's pharmaceutical sector that puts it at the top of the food chain.

With nearly a quarter of the country's pharmacies, a national wholesale division that links manufacturers with every community pharmacy, and enviable brand credibility on virtually every major high street, it's crystal clear why the former engineer now sits at the top of the power league.

So, when he has a view on how he plans to tackle the retail challenge posed by supermarkets or on delivering more health services through Boots stores, it's worth a second look.

Last week C+D was granted a rare video interview with Mr Pessina and AB's chief executive Andy Hornby. Hearing their views on the future challenges and opportunities AB faces both as retailer and healthcare provider makes for illuminating reading (p4). The business has delivered a 50 per cent increase in profit in three years, and last year saw an 8 per cent rise in pharmacy services income – and there is every reason to believe Mr Pessina will achieve his mantra of sustained double digit growth.

Cynics will argue that the company's growth comes at the expense of independent pharmacy – though Mr Hornby is adamant that it is "massively" in Alliance Boots' interest for independents to prosper.

But perhaps it's worth looking at how the company is broadening the health services it offers through its pharmacies, partnering with GPs and nurses and differentiating its offerings from the supermarkets, and pick out the lessons that can be learned.

As Mr Pessina says, double digit growth is a mindset, and if you believe in this mindset, you will achieve it.

Gary Paragpuri, Editor

Alliance Boots chief sets sights on sustained double digit growth

EXCLUSIVE Stefano Pessina says business tie-ups and new products will drive expansion

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Alliance Boots is targeting sustained double digit growth in the future, the company's executive chairman Stefano Pessina has revealed in an exclusive interview with C+D.

Speaking in a rare joint interview with AB chief executive Andy Hornby, Mr Pessina said: "I believe double digit growth is sustainable – it is our mantra and we strongly believe we can achieve it."

Trading profit at the pharmacy-led health and beauty group has increased 50 per cent to £1 billion following the takeover of the company by Mr Pessina and private equity firm KKR in 2007.

Mr Pessina voiced confidence this level of growth can be maintained. Alliance Boots would achieve its target through a number of routes, he revealed.

This included organic and external growth, new product development and through business partnerships such as the company's tie ups with Waitrose and Mothercare in the UK and Procter & Gamble in Italy.

Costs had also been taken out of Alliance Boots since the company became privately owned, but Mr Pessina stressed that "cutting costs did not mean cutting people". Instead, it was about "changing the way the company works in order to be more efficient with the same people".

He added: "We are convinced that if you want a growing business, you must have people to sustain the growth."

Chief executive Andy Hornby also explained how the high street chain was responding to the challenge posed by supermarkets. Alliance Boots offered products and services that supermarkets did not. For example, "leading-edge beauty, a broader range of services around our pharmacies and new product development" in areas in which supermarkets did not invest, Mr Hornby said.

The multiple was further investing in "local pharmacy which was not a primary goal of the supermarkets", he added.

The new government's NHS reforms also offered opportunities for community pharmacy, Alliance Boots said. "It would be a cynic who did not think that over the next 10 years pharmacists aren't going to broaden the basic healthcare advice that they give," Mr Hornby said.

Mr Pessina added that although the government had "sometimes squeezed [community pharmacy] a little too much and not recognised the true costs they have sometimes", it did "understand that pharmacy could contribute to delivering healthcare".

And he stressed that Alliance Boots was committed to supporting existing pharmacy organisations develop the sector.

"We absolutely support the organisations which are there. Our pharmacies are exactly similar to the pharmacies of our customers; we don't have a conflict of interests," Mr Pessina said.

Alliance Boots chief executive Andy Hornby on:

The company priorities:
"Getting our customer proposition right, getting the support for beauty products right and product development right, and support for our pharmacists in order to drive the healthcare business, has to be the number one key priority."

Growth opportunities:
"It'll be less driven by new stores... it'll be more driven by new services, more healthcare activity in our stores, broadening the range of activities that our pharmacists do and really building on the beauty offering."

The supermarket challenge:
"We're not complacent but we think there's plenty of room in our markets to operate alongside the supermarkets, to keep investing in the kind of products and services that are not core to a supermarket offering."

The Pessina mantra:

"We are a company with a clear vision, with a strategy that has always been consistent and our people are enthusiastic and motivated."

"Double digit growth for me is a kind of mindset. If you have this mindset and you believe it, at the end you are able to achieve it."

Stefano Pessina and Andy Hornby on the future for Boots. Watch the exclusive video

www.chemistanddruggist.co.uk

Where next for distribution? Watch our video interview with AB's Ornella Barra

www.chemistanddruggist.co.uk

Minor ailments schemes fall prey to PCT cost cuts

EXCLUSIVE Trusts decommission services despite patient praise

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PCTs across the country are scrapping pharmacy services including minor ailments schemes in a bid to cut costs, C+D understands.

Numark managing director Tony Mottram and Rowlands commercial director John D'Arcy both said they had seen some minor ailments schemes being halted. PSNC's head of NHS services Alastair Buxton said he too had heard about some pharmacy services, including a vascular risk assessment programme, being reconsidered.

"At a local level, an increasing number of Numark members are reporting that MAS schemes are being cut back," Mr Mottram said. He added: "Despite positive feedback from patients, GPs, pharmacists and their teams, services are being decommissioned or formularies reduced."

"We believe that a national service should be the next stage for the pharmacy contract, but whilst existing services are being cut this doesn't seem imminent," he warned.

Mr Buxton said although cuts were disappointing, it was not surprising to see them in the current financial climate. "Decommissioning is one of the buzz words in PCTs at the moment, and it's not just for pharmacy services," he added.

A Department of Health spokesperson said the NHS would need to deliver significant savings over the coming years. But they added: "This is not about cutting the frontline services, but about finding the efficiencies to meet increasing demand. Better patient care can cost less, and doctors and pharmacists have a crucial role to play in improving the quality of care and making the NHS more efficient."

According to Mr Buxton, decommissioning some services could be short sighted, and he said LPCs should push the cost saving benefits of pharmacy services in their negotiations. And Mr Mottram called for action to halt the changes and said with the NHS shake-up the schemes should be given greater priority.

Mike Holden, chief officer of Hampshire & Isle of Wight LPC, said decommissioning was always a danger and that pharmacy needed to show it was delivering the desired outcomes from services.

"PCT short-termism makes no sense" – read Lloydspharmacy director Andy Murdock's view
www.chemistanddruggist.co.uk

Shortages force medicines loans

A contractor in Essex has been bailing out other local pharmacies by loaning them thousands of pounds worth of medicines in short supply.

Chansons Pharmacy in Rainham has built up a stock of branded medicines by ordering drugs as and when they become available from wholesalers.

It is now having to lend these to other pharmacies to ensure patients receive their medicines quickly.

Chansons Pharmacy owner Bakul Patel told C+D: "There are several pharmacies that will come to us to borrow because it's quicker than getting [drugs] from the manufacturers."

Mr Patel has to spend time keeping running tabs for the pharmacies, and one has now borrowed several thousand pounds worth of medicines from him.

Mr Patel described the branded medicines being borrowed as "the usual suspects, the ones that are in short supply". He explained he had resorted to building up his stocks to ensure continuity of medicines supply for patients. "It's to provide continuity. I've had to invest quite heavily in the stockholding."

Mr Patel said he felt a responsibility to lend the drugs to local pharmacists when they needed them. But he warned building up his stockholding had affected cash flow. "We're not allowed to feel the recession," he said. And he added that his business could be hit, for example, if drug prices drop in the future.

PSNC said it was not unusual for pharmacies to lend others medicines, although it added that it might be at this level. **ZS**

Bakul Patel has increased stock to help patients get their medicines quickly

Are stock shortages still affecting you? Let us know by completing C+D's survey and you could win an iPod Shuffle
www.chemistanddruggist.co.uk

In brief

No delay to contract

The health white paper will not stall negotiations on the pharmacy contract, PSNC has said. Alastair Buxton, PSNC head of services, said talks continued with the DH but recognised there were uncertainties over the future.
www.chemistanddruggist.co.uk

Magnapen end

Magnapen syrup will be debranded to generic co-fluampicil 250mg/5ml when current branded stock is exhausted in November 2010, Wockhardt has announced. Magnapen 500mg powder for injection will continue to be available.

Rosiglitazone ruling

The European Medicines Agency was set to rule on the safety of rosiglitazone this week following two studies that raised concerns over cardiovascular risk. One study found, compared with pioglitazone, rosiglitazone was associated with increased risk of stroke, heart failure and all-cause mortality. The second found patients on the drug had an increased risk of MI.
www.chemistanddruggist.co.uk

C+D wins four awards

C+D has won four international editorial awards in the 2010 Tabbie Awards. C+D beat off competion from more than 500 rivals to scoop a gold award for Chris Chapman's feature on swine flu, silver awards for news coverage and the PCT Investigation, and a bronze award for its Category Focus series of marketing features.

GPhC debates conduct

As C+D went to press, the General Pharmaceutical Council was set to meet to agree on matters including student codes of conduct and just disposal of legacy cases. See more in C+D's August 7 issue.

Next week's C+D

There will be no printed issue of C+D on July 31, so for all the latest community pharmacy news go to **www.chemistanddruggist.co.uk**

In brief

NCSO update
The Department of Health and National Assembly for Wales have agreed to allow NCSO endorsements for the following item for July prescriptions: gabapentin 300mg capsules.

Supervision plea
The RPSGB has urged pharmacists to air their views on supervision to inform a future lobbying campaign on the issue. The Society has asked members to provide feedback on eight guiding principles of any supervision changes.
www.chemistanddruggist.co.uk

HIV rates up in over-50s
HIV infections in patients over 50 years are up by 60 per cent, the HPA has announced. More than half of the new cases in over 50s between 2000 and 2007 were diagnosed at a point late in the disease, compared with a third in young adults.

Road safety campaign
A road safety group has launched a campaign to highlight the dangers of drinking while taking prescription medicines. Pharmacists can download an awareness leaflet on the GEM Motoring Assist initiative at **www.motoringassist.com/motoronmeds**

MRSA cases fall
Infections from MRSA and Clostridium difficile (C. diff) have fallen by around a third in England and Wales, the Health Protection Agency has announced. Cases dropped from 2,935 MRSA and 36,095 C. diff infections in those older than two in 2008-09 to 1,898 and 25,604 respectively between April 2009 and March 2010.
www.chemistanddruggist.co.uk

Awareness success
A pharmacy-based cancer awareness scheme resulted in 161 patients being referred to their GPs. The Essex-based scheme promoted the signs and symptoms of colorectal and skin cancer to 2,750 participants.
www.chemistanddruggist.co.uk

Clampdown on lengthy methadone treatment

Maintenance treatment to have fixed time limit, NTA plan says

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Long-term maintenance therapy on methadone will be scrapped, with time limits on supply set to drive addicts to abstinence, the National Treatment Agency for Substance Misuse (NTA) has said.

In a business plan released earlier this month, the NTA said it would "take forward the government's ambition for a rapid transformation of the treatment system".

The move follows comments from Prime Minister David Cameron in April, when he said methadone treatment "does not deal with the problem" of drug misuse in a live TV debate (C+D, April 24, p4).

Key polices include extending strict time limits to end open-ended substitute prescribing, already in use in prisons, to community settings and implementation of "payment by results" strategies, the NTA said.

"The intent is to see a fundamental shift in the balance of treatment for opiate addiction, away from long-term maintenance towards abstinence and long-term recovery," the NTA plan stated.

James Wood, of Wicker Pharmacy, which serves a number of substance misusers, said the move would have a large impact on pharmacy, but that it was hard to predict how effective the new policy would be. "There's a lot of evidence that how we are doing drug treatment at the moment works," he added.

New treatment strategies, including those to tackle 'legal highs', would also be developed and implemented, the NTA said.

The NTA is a special NHS authority that oversees drug treatment in England. The NTA business plan follows a green paper by think-tank the Centre of Social Justice, established by former Tory leader Iain Duncan Smith, which called for the NTA to be scrapped and replaced with a board more focused on recovery programmes.

Can you supply CDs without a properly dated prescription?

See Ethical Dilemma on p20

Clinical debate — C+D's Chris Chapman looks at the evidence behind the headlines

No need for aspirin when flying

Air travel poses no significant threat to cardiovascular health for most patients, according to media outlets this week. So what does this mean for sunseekers preparing to jet off on their summer holidays when it comes to preventing a deep vein thrombosis (DVT)?

The headlines spring from new guidance, published in Heart, from the Working Group of the British Cardiac Society (BCS). The guidance follows a House of Lords Science and Technology Committee report in 2007, which found that evidence on whether to use aspirin to prevent DVT was contradictory. According to the Lords, 20 per cent of long-haul passengers were taking aspirin, despite experts branding it a "relatively ineffective intervention".

The BCS says the absolute risk of getting a venous thromboembolism for flights longer than four hours is about one in 6,000. However, the guidance says this is about the same as the risk of travelling by car, bus or train over a similar period.

So should aspirin be used as prophylaxis against DVT? The BCS guidance is categorical: aspirin is not recommended. According to one study, aspirin just served to give 13 per cent of participants gastrointestinal upsets.

That said, the guidance does recommend compression socks for patients at moderate risk. This is in line with a Cochrane review published in January.

The meta analysis looked at 10 randomised controlled trials of the socks, and found 50 of the 2,637 flyers in trials developed a symptomless DVT – three wore socks, 47 didn't.

Boiling it down, the BCS advice is that patients who have no history of DVT, no surgery in the past month and no known risk factor, should just keep mobile and well hydrated, avoiding alcohol, caffeine and hypnotics.

Patients with a previous DVT, surgery in the preceding two months, thrombophilia, who are pregnant or are obese, should use compression socks, but otherwise the advice remains the same. It's only patients with surgery within four weeks or a previous DVT and a risk factor (including cancer) who need to take precautions, although some (such as those in casts) will need to take specialist advice.

To discuss this subject in private with your pharmacy colleagues, join the debate in C+D's Linkedin group at www.linkedin.com – search for Chemist and Druggist.

Chat with Chris on Twitter: www.twitter.com/CandDChris

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Product Information: Solpadeine Max Soluble Tablets. Presentation: Paracetamol 500 mg, Codeine Phosphate Hemihydrate 12.8 mg and Caffeine 30 mg. **Uses:** Short term treatment of acute moderate pain not relieved by paracetamol, ibuprofen or aspirin alone. **Dosage and administration:** Dissolve in water before taking. Adults and children, 12 years and over: Two tablets up to four times daily. Not more than 8 tablets in 24 hours. Children under 12 years: Not recommended. Do not take for more than 3 days without consulting a doctor. **Contraindications:** Known hypersensitivity to ingredients. **Precautions:** Can cause addiction. Use for 3 days only. Renal or hepatic impairment, non-cirrhotic alcoholic liver disease. Salt restricted diet. Sufferers from persistent headache and withdrawal symptoms should consult a doctor. **Interactions:** Warfarin or other coumarin anticoagulants, domperidone, metoclopramide, colestyramine, monoamine-oxidase inhibitors, mexiletene. **Pregnancy/lactation:** Do not use without medical advice. **Side effects:** Paracetamol: rarely, hypersensitivity including skin rash; very rarely, reports of blood dyscrasias (not necessarily causally related). Codeine: constipation, nausea, vomiting, vertigo, difficulty with micturation, dry mouth, rashes, urticaria, dizziness, drowsiness, restlessness and irritability. **Legal category:** P. **Product licence number:** 00071/0234. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** 16s £3.49, 32s £5.89. **Date of last revision:** January 2010. Solpadeine is a registered trade mark of the GlaxoSmithKline group of companies.

* Source: Neilsen: Total Chemists MAT Value & Unit Sales (11.12.09)

Check out our interactive guide to what's hot and what's not in the white paper
www.chemistanddruggist.co.uk/healthwhitepaper

Dispensary talk

Is the Lib-Con health white paper good news for pharmacy?

"Some have been saying it is a good thing for pharmacy and Earl Howe said the white paper is an opportunity for pharmacy, but I think it is too early to tell."
David Evans, WR Evans (Chemist) Ltd t/a Manor Pharmacy, Ilkeston, Derbyshire

"I think some of it sounds good, especially the PCTs being restructured or abolished. I think that bureaucracy has got more top heavy."
Gurminder Sall, Jeeves Chemist, Iver Health, Buckinghamshire

Web verdict

Yes 29%

No 71%

Armchair view: Pharmacists are not convinced Andrew Lansley's white paper will offer them much, with 71 per cent of respondents reporting they do not think it is good news for pharmacy.

Next week's question:
Has the minor ailments service been scrapped in your area? Vote at **www.chemistanddruggist.co.uk**

Health White Paper

Lansley demands open error reporting

Reducing patient harm from mistakes priority for new NHS board

Max Gosney
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Pharmacists will face increasing pressure to cut dispensing errors and report mistakes under Andrew Lansley's NHS reform programme.

Reducing error rates is set to become a core performance measure of the new NHS Commissioning Board that will dictate pharmacy funding, the health secretary has revealed.

The board will be assessed against a five-part NHS Outcomes Framework that includes a pledge to protect patients from avoidable harm.

The board will be tasked with threee key targets on patient safety:

- reducing the number of incidents reported
- reducing the severity of harm caused by incidents
- reducing the number of similar incidents.

The board will also be tasked with establishing an open culture on reporting mistakes.

The proposals were revealed in a consultation on delivering a more accountable NHS published by the government this week.

"Organisations must be able to learn from incident reports and make tangible changes that improve safety and the public's confidence," the consultation stated.

The document comes as part of the health reform programme set out in the Liberating the NHS white paper of last week.

The full NHS Outcomes Framework proposed includes:

- preventing premature death
- boosting the quality of life for chronic condition sufferers
- helping patients to recover from ill health and injury
- ensuring people have a positive experience of care
- protecting patients from avoidable harm.

The proposals are open for consultation until October 11.

The NHS Commissioning Board is due to launch next April.

Lansley's NHS challenge

- **Reduce error rates**
- **Reduce severity of errors**
- **Cut out repeat mistakes**

Have your say on the new NHS outcomes framework

www.chemistanddruggist.co.uk/healthwhitepaper

DH: no investigation into generics

The Department of Health (DH) has refuted claims by The Mail on Sunday newspaper that a review of generic drug prices has been launched.

A spokesperson from the Department of Health said: "No new review of generic pricing has been launched but where a price has significantly increased, as happens from time to time, the Department reviews these on a case by case basis to determine the cause of the price increase and its rationale."

The comments came after The Mail on Sunday published an investigation into the cost of generic medicines.

The newspaper alleged generic firms had profited from rapid price rises in certain medicines since 2008. The newspaper also said the finding had prompted the DH to launch a review of prices.

The British Generic Manufacturers Association (BGMA) said in a statement that the price of medicines had actually dropped since 2008. A spokesperson said: "The prices of generic medicines in the UK are the lowest in Europe.

"The low prices of the majority of generic medicines are maintained by competition between suppliers."

The BGMA statement was supported by manufacturers Actavis and Teva, which were both referenced in The Mail on Sunday investigation. **HF**

Manufacturer launches legal action

Generic medicine firm Auden Mckenzie has announced it is launching legal action against The Mail on Sunday, following its article on generic drug pricing.

The article, which appeared on July 18, made claims regarding the cost of medicines provided by Auden Mckenzie. The Mail on Sunday said it stood by the story.

Bio-Oil® is a specialist skincare oil that contains a combination of natural oils and vitamins, together with the breakthrough ingredient PurCellin Oil™. It was developed in 1987 and is today the number one selling scar and stretch mark product in 12 countries. It is available at pharmacies at the recommended price of £8.95. For comprehensive product information please visit bio-oil.com. Bio-Oil® is a product of Union Swiss, successfully treating skin since 1954.

Check out what's on TV this week
www.chemistanddruggist.co.uk/prodnews

Two key GSK brands get POS campaigns

GSK Healthcare has announced the launch of two point of sale (POS) campaigns for pain relief brands, Panadol Advance and Solpadeine Max Soluble.

Panadol Advance is set to be the focus of an interactive point of sale campaign that will feature a counter display unit.

Shoppers will be invited to press a button on the unit, which also holds stock, lighting up two panels that show the speed at which the product disperses in the stomach compared with standard paracetamol, says the company.

The Solpadeine Max Soluble 'Paint the Town Red' campaign will feature the theme, 'Share Your Pain with the Pharmacist'.

The POS kits are available now from territory business managers, via www.mypharmassist. co.uk or by calling the pharmacy helpline on 0845 762 6637.

The campaign will also feature traditional standees, window clings, wobblers and shelf strips.

Prices: £1.45/16 Panadol Advance; £2.79/32 Panadol Advance; £5.89/32 Solpadeine Max Soluble
Pip codes: 340-6535; 340-6543; 353-7461
GSK Healthcare
Tel: 0845 762 6637
www.mypharmassist.co.uk

Market focus

- The total adult pain relief market is worth £355.2 million a year, of which pharmacy commands a £178.9m share.

Source: Category Report Pain Relief (GSK), January 2010

Precise dosing from Cetraben

Genus Pharmaceuticals has redesigned and repackaged Cetraben Emollient Bath Additive Dispenser.

The new design includes a transparent contoured bottle for easy grip and a measuring device with a spill-resistant filling mechanism for accurate dosing.

The measuring device is set to 10ml, but if it is filled above this, release of pressure on the outside of the bottle allows the excess to be sucked back into the bottle, says the company.

A demonstration can be viewed at http://tiny.cc/3x1iw.

Price: £5.75/500ml
Pip code: 296-3734
Genus Pharmaceuticals
Tel: 01635 568 400

Timotei back on the telly

Unilever UK has announced it is relaunching its haircare brand Timotei this month.

The brand will be the focus of an "Inspired by Nature" television campaign and has also been reformulated, according to the company.

Customers who remember the product and its advertising campaigns of the 80s and 90s may be attracted to the brand again, the company hopes.

Additionally, it introduces a younger audience to the products, says Unilever.

Timotei is available in eight variants, offering 15 SKUs.

Prices and Pip codes: See C+D Monthly Price List or www.cddata.co.uk
Unilever UK
www.unilever.co.uk

Naturtint packs reflect organic ingredients

Naturtint Green Technologies has reformulated and repackaged Naturtint hair products.

The products, which do not use ammonia, have been reformulated to include selected certified organic ingredients, and repackaged to convey this message with a redesigned logo, according to the company.

Efforts have been made to step up pharmacy relations in conjunction with the reformulation and repackaging, says Naturtint.

The packs now contain the reformulated Naturtint Nutrideep Multiplier protective cream in a 35ml sample size and Naturtint Shampoo trial sachet, the company adds.

A new colour has also been added – the 2.1 Blue Black colour brings the number of colours in the range to 30.

Prices: From £7.99
Pip codes: See C+D Monthly Price List or www.cddata.co.uk
Naturtint Green Technologies
Tel: 0845 601 8129

Durex head of marketing talks to C+D

Durex head of marketing Ruth Gresty (pictured) explains to Hannah Flynn how pharmacists can use Durex's summer campaign to boost sales of the range.

Q How does the campaign work?

The "Love Thursday" campaign is designed to make people think about sex once a week, midweek. However, it is not overly sexy and it is not screening sex. It is quite subtle. We already have a large number of people subscribing for email alerts, which are part of the campaign, through the website.

Q What does this campaign offer pharmacy?

We have got a big sales force going into pharmacy who are telling pharmacists how they can get involved. We will also be selling Durex units to pharmacists so they can display the range and we are working on an information pack for staff.

Q How will this campaign increase sales?

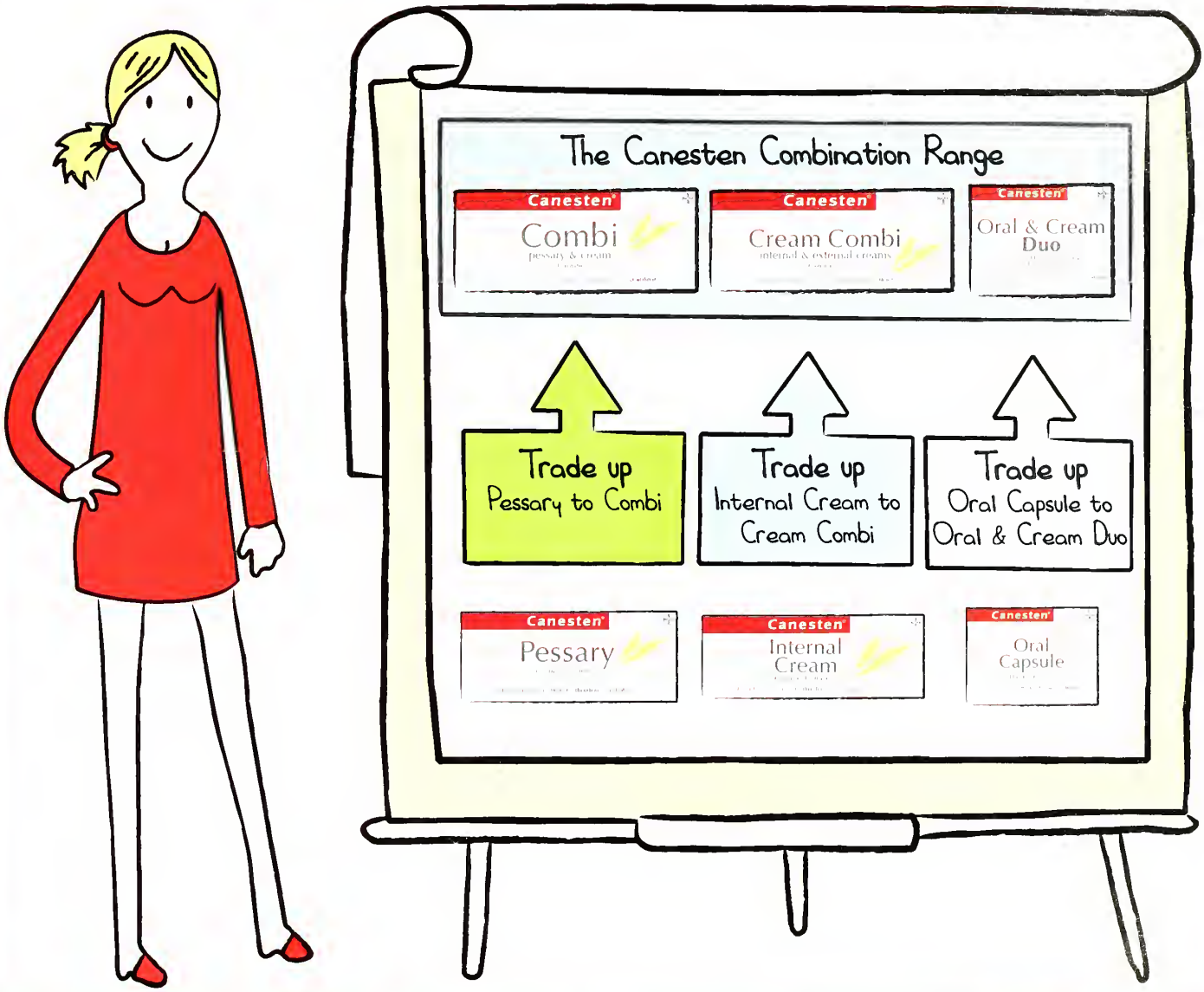
This is a way of making consumers think about their sex life and we want to make people think, 'It would be nice to get that,' or, 'I need to buy my condoms today'.

Q How can pharmacists help their customers with sexual health purchases?

Younger people prefer to go into a pharmacy, preferably a big store, to buy their condoms. Pharmacists can help them by making sure condoms are more accessible and not behind the counter. People need to be able to self-select them. Shop owners shouldn't worry about stocking them, they don't look seedy.

Canesten®

Trade up your customers to Canesten Combination treatments



Thrush is an internal infection, but customers often present with external symptoms too.

BAYER

For more information on the Canesten range please visit the Canesten website at **www.canesten.co.uk/hcp**

CGY124 June 2010

Get up to speed on the white paper
www.chemistanddruggist.co.uk/healthwhitepaper

GP-led consortia: good news?

As the dust settles on last week's white paper, **Chris Chapman** asks how community pharmacy will fare when GP-led consortia take over commissioning

The ink may have dried on last week's health white paper, but the ramifications are still reverberating around the NHS. Of all the changes mentioned in the radical reforms, the greatest is possibly the abolition of PCTs, creating GP-led consortia to run local commissioning – a system that will be met warily by many in the pharmacy sector.

It's not the first time doctors have been handed such powers. Practice-based commissioning (PBC), which was first announced in 2005, also gave them control. But the health white paper labels PBC a "flawed policy framework" that confused responsibilities and "failed to transfer real freedom and responsibility to GP practices". While PBC was hoped to bring in a new era of local commissioning, in reality the results were as patchy as its PCT-based counterpart.

But Georgina Craig, of NHS Alliance, says the new system will be different. "GPs will have more control over the budget," she says. "Under PBC the budget sits with PCTs, so PBC gave very little freedom. Under GP commissioning they will have a lot more flexibility."

"Giving GPs responsibility for commissioning care and managing NHS budgets should result in services being more closely aligned with patients' needs," agrees King's Fund chief executive Chris Ham. However, he adds: "But while some GPs will seize this opportunity, many others may be reluctant to come forward and lack the skills needed."

The skills issue raises questions about just who will sit on the boards. As healthcare professionals at the coalface of primary care, pharmacists are just as aware, if not more so, of local public health needs as GPs. And as contractors often without the luxury of a practice manager to balance the books, many in the sector will be far more adept at balancing budgets than their medical colleagues.

Health secretary Andrew Lansley has already said the consortia will be "general practice-led, not general practitioner-led", indicating that there will be some room for other healthcare professionals to sit at the table, possibly leading to an increased recognition of pharmacists' expertise.

Hassan Argomandkhah (right) and Tom Kinloch – working together to raise local health awareness. But will the partnership be replicated on GP consortia?

But many are not convinced pharmacists will get involved in the commissioning role of the consortia.

"There is a desire for a wider commissioning role," says PSNC head of NHS services Alastair Buxton. "But I suspect pharmacists will be more involved in provision."

Yet engagement with GP-led consortia will be hard to avoid. Under the new-look NHS, pharmacy will have three potential commissioners: the NHS Commissioning Board, a national structure that will commission pharmacy services centrally; GP-led consortia, and local authorities, which will be able to instigate public health initiatives.

And, according to Ms Craig, as public health is not an area where contractors can look to make significant profit: "A lot of the services that will be money spinners will be commissioned through GP-led consortia."

The consortia will also be able to fund schemes that produce results but wouldn't be seen as economically viable, Ms Craig adds. Monitor, a body that will regulate commissioning, will be able to provide grants to underpin schemes, she says.

The consortia may be difficult to avoid then but, thinking positively, the commissioning process will be far more transparent, vanquishing some pharmacist's concerns of favouritism when it comes to selecting providers.

And pharmacists could consider what skills they can bring to bear, says Ms Craig. "You need to know what commissioning is... it's being able to help the group understand the needs of the local population. Pharmacy sits on a wealth of information... but if pharmacy collected data, that could be a real asset."

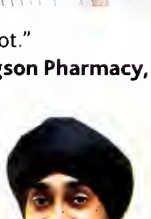
Many contractors may feel uncomfortable with sharing patient data. Yet anonymised data has been used in general practice for years, resulting in everything from population overviews to study results and risk algorithms. Pharmacists hold data not only on prescriptions, but on the prevalence of many conditions in groups of the community that may not present to general practice.

Doubts still remain, but GP consortia will play a key role in commissioning going forward. And while alternative commissioning routes will exist – through local authority contracting and the NHS Commissioning Board – it will be the pharmacists that get involved with the groups that will reap rewards.

Some pharmacists ask if the sector can afford to throw itself in to the local system. It may be that pharmacy can't afford not to.

Your views

"The NHS is in the process of slashing costs. Providers will need to offer more for less. How low can we go? Can we afford to engage? Probably not."
Amish Patel, Hodgson Pharmacy, Longfield, Kent



"At this stage it is difficult to ascertain whether there will be increased opportunities for pharmacies to provide commissioned services, as we currently do not understand the make-up of the consortia, ie, will pharmacists have a place of right?

I think the need for community pharmacies to engage with local stakeholders is the same as always – we must do more and do it more often."
Ajit Malhi, head of marketing services, AAH

Will GP-led consortia be good for pharmacy?

Vote at www.chemistanddruggist.co.uk or discuss privately via the C+D Linkedin group at www.linkedin.com – search for Chemist and Druggist

now you can swap some cigarettes with nicorette® inhalator as a safer option to smoking

nicotine

NICORETTE® Inhalator is first to market with a new indication for those unwilling or unable to quit smoking. By replacing some cigarettes with NICORETTE® Inhalator you'll be providing a safer option when they aren't yet ready to break free from cigarettes.

For every cigarette, there's a nicorette®

www.nicorette.co.uk

As soon as they are ready, smokers should aim to stop smoking completely

Nicorette Inhalator Product Information:
Presentation: Inhalation cartridge containing 10mg nicotine for oromucosal use via a mouthpiece. **Uses:** Relieves and/or prevents craving and nicotine withdrawal symptoms associated with tobacco dependence. It is indicated to aid smokers wishing to quit or reduce prior to quitting, to assist smokers who are unwilling or unable to smoke, and as a safer alternative to smoking for smokers and those around them. It is indicated in pregnant and lactating women making a quit attempt. **Dosage:** ***Adults and Children over 12 years of age:*** Nicorette Inhalator should be used whenever the urge to smoke is felt or to prevent cravings in situations where these are likely to occur. Smokers willing or able to stop smoking immediately should initially replace all their cigarettes with the Inhalator and as soon as they are able, reduce the number of cartridges used until they have stopped completely. Smokers aiming to reduce cigarettes should use the Inhalator, as needed, between smoking episodes to prolong smoke-free intervals and with the intention to reduce smoking as much as possible. As soon as they are ready smokers should aim to quit smoking completely. When making a quit attempt behavioural therapy, advice and support will normally improve the success rate. Those who have quit smoking, but are having difficulty discontinuing their Inhalator are recommended to contact their pharmacist or doctor for advice. **Contraindications:** Children under 12 years and Hypersensitivity. **Precautions:** Unstable cardiovascular disease, diabetes mellitus, G.I disease, uncontrolled hyperthyroidism, phaeochromocytoma, hepatic or renal impairment, chronic throat disease, obstructive lung disease or bronchospastic disease. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and both less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. Best used at room temperature. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Cough, irritation of throat and mouth, headache, nasal congestion, nausea, vomiting, hiccups, palpitations, GI discomfort, dizziness, reversible atrial fibrillation See SPC for further details. **RRP (ex VAT):** 6-Starter pack £6.99 42-Refill pack £21.99. **Legal category:** GSL. **PL holder:** McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **PL number:** 15513/0179. **Date of preparation:** March 2010
Date of preparation: May 2010 05761

Why have they reinvented the NHS wheel?

"'NO DECISION ABOUT ME WITHOUT ME' COULD BE A SOUND BITE FROM A CHEESY AMERICAN SELF-HELP TAPE"

The process of change is a strange thing. "A change is as good as a rest," they say, or "out with the old and in with the new!", suggesting new is always better, faster, brighter, smarter. And I'm really starting to hate the expression "May you live in interesting times", because people say it to mean "If you're not panicking, you haven't understood the situation!".

Of course, we all know that public services can only ever improve, and new policies must always be an advancement, so a radical shake-up of the NHS was inevitable – after all, a new government can't just put its feet up and say "If it ain't broke, don't fix it!", so we have to have yet another white paper – this parliament's attempt to reinvent the NHS wheel.

And I wish I could get excited, I really do, but I fear they've thrown the baby out with the bath water in the decision to do away with PCTs and SHAs because, however we felt about their varying engagement with pharmacy, they had the structure to stand up against the GP commissioning groups. Yet this white paper seems to be centred on GP consortia, when it is supposed to be centred on the patient (am I alone thinking "No decision about me without me" is a sound bite from a cheesy American self-help tape?).

Now let's not confuse this with GP fundholding – that was just about manageable for the average surgery. No, this GP commissioning consortia is a much bigger fish and, without the sort of support staff in place to manage it all, I fear some consortia may bite off more than they can chew. Let's not forget that there is a reason surgeries have a practice manager, and our nearest regularly assures me that "the kids" – as she calls them – couldn't organise a chimps tea party. So what happens to local payments and services while our new masters find their way?

And to say patients will decide who provides their care just shows we have learnt nothing from Choose and Book, the attempt to push up secondary care standards through 'market forces'. As patients we don't want to choose – that's why we've come to a healthcare professional to tell us where we should receive treatment – otherwise I'd be getting my appendectomy off eBay.

I also don't want my GP to snatch my prescription back saying "I'm not only your doctor, I've commissioned myself to be your dispenser too!" But there won't be a plurality of suppliers lined up to offer services, unless they have an expectation of sustainable business, so it's all very well for everyone to say this is an exciting opportunity for pharmacy, but what about the opportunities of LPS and vascular screening and all the other exciting services that came and went?

This particular wheel just keeps going round, and I fear we may not learn from the past.

Deliver more for less by improving adherence

The health secretary's call for a greater focus on clinical outcomes is to be welcomed. Community pharmacists know all too well how easily the NHS can be distracted by process; and how the rush to meet short-term benchmarks can work against patients' long-term interests.

If there was ever an area where flurries of activity drew attention away from outcomes it is medicines therapy. The health service spends billions a years on expensive medicines. These drugs are prescribed and dispensed in good faith, and this activity is dutifully recorded and analysed. What is all but ignored is that a huge proportion of these medicines are wasted or inappropriately used; recent research puts this as high as 55 per cent.

Medicines that are not used as directed will not work in favour of the intended clinical outcome; they will be at best ineffective and will not work in the best interests of the patient. Research suggests that between 11 per cent and 20 per cent of all hospital admissions, A&E visits and repeat doctor visits are a direct result of non-adherence.

Andrew Lansley has argued that a patient-centred NHS should look to live by the mantra "No decision about me without me". This principle is at the very heart of pharmacy-provided adherence services. These services bring patients into the decision-making process and serve to make them partners in their own care. Patients on complex courses of medicine often feel overwhelmed and under-informed; a simple conversation with a supportive pharmacist can restore their sense of control and understanding.

The white paper envisions an "important and expanding role" for pharmacy in optimising the use of medicines. The next step in the development of this role should be empowering community pharmacists to offer personalised guidance to patients as soon as they embark on a new medicines regimen. A national First Prescription Service would do just this; and take the support and guidance pharmacists already offer to the next level.

Adherence services should be seen as a fundamental part of pharmacy's role, not as a 'nice-to-have' clinical add-on. If the medicines pharmacists dispense are to achieve their desired clinical outcome, and help rather than hinder high quality care, they must be used correctly. This will require consistent support for adherence; which community pharmacists, by virtue of both their expertise and accessibility, are ideally placed to provide.

Pharmacy-provided adherence services are cost effective, patient-centred, and focused on optimising clinical outcomes. In this regard they fit perfectly with the government's vision for the NHS. This alignment of goals presents a tremendous opportunity. The NHS must convert these goals into a service, and community pharmacy must deliver it.

Sue Sharpe is chief executive of PSNC

"ADHERENCE SERVICES SHOULD BE SEEN AS A FUNDAMENTAL PART OF PHARMACY'S ROLE, NOT AS A 'NICE-TO-HAVE' CLINICAL ADD-ON"

Nicorette® Inhalator

nicotine

first to market with a new indication for those unwilling or unable to quit smoking

In the UK approximately 10 million adults smoke cigarettes;[1] 50% of smokers are not happy with their current smoking habit, of these 12% are planning to stop abruptly and 35% are either planning to reduce the amount of cigarettes they smoke or reduce the amount they smoke with a view to stopping altogether. However, with no help or support the power of nicotine addiction means that few will actually succeed. Research has shown that only 3% of smokers will succeed in an unaided quit attempt in any 12-month period.[2]

A new way to help smokers quit

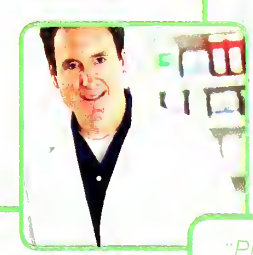
Pharmacists are among the most accessible of all healthcare professionals. Everyday almost two million people in the UK visit a community pharmacy for health advice[4] making pharmacists ideally placed to provide support to those who are thinking of stopping smoking. Nicotine Replacement Therapy (NRT), along with advice and support, is an effective and simple way to help smokers reach their ultimate goal of quitting.

The Inhalator is a unique format of NRT which acts as a cigarette replacement to help control cravings, with up to one in three smokers remaining abstinent at 12-weeks.[5,6,7,8] It is made up of a mouthpiece through which the user draws in nicotine by active inhalation. Held like a cigarette, it occupies the hand as well as mimicking the hand-to-mouth action.

As well as controlling cravings, Nicorette® Inhalator has been shown to relieve nicotine withdrawal symptoms associated with tobacco dependence[9], and is indicated:

- To aid smokers wishing to quit
- To aid smokers to reduce the amount of cigarettes they smoke prior to quitting
- To assist smokers who are unwilling or unable to quit smoking by replacing some cigarettes with Nicorette® Inhalator for a safer option to smoking

The extension of the indication to encompass those unwilling or unable to quit smoking means you can provide Nicorette® Inhalator as a safer option to smoking when smokers are not yet ready to break free from cigarettes. Data suggests that for smokers unable or not interested in giving up abruptly, a softer and more gradual approach should be considered. Such an approach may produce more people wanting to quit.[10] In fact, one in three of those who halve their smoking with Nicorette® Inhalator or gum have been shown to quit in one year.[11]



Smoking cessation – one step at a time

Five out of 10 smokers are not happy with their current smoking habit.[1] So that the support given to smokers is well-matched to their individual needs, pharmacists should consider the following ways of helping their customers:

- *'Abrupt Quitter' strategy – a smoker who is able to stop smoking immediately, often with the help of NRT and behavioural support.*
- *'Reduce to Stop' strategy – used to encourage those who are not 'abrupt quitters' to build towards a quit attempt by gradually reducing the number of cigarettes used.*
- *'Safer Option to Smoking' strategy – used for those unwilling or unable to quit smoking by replacing some cigarettes with Nicorette Inhalator, a safer option to smoking for when smokers are not yet ready to break free from cigarettes.*

Nicorette Inhalator can now be used in a novel way which will help those smokers who 'cannot quit yet' to replace some cigarettes, as a safer option to smoking. Pharmacists can help patients, who have previously felt they cannot quit, take the first step on their journey with the end goal – smoking cessation – in sight.

Community pharmacists are encouraged to advise on the correct use of nicotine replacement therapy (NRT) products and to provide behavioural support to aid smoking cessation.

For further information on the Nicorette Inhalator visit: www.nicorette.co.uk

"Pharmacists are in an ideal position to encourage the use of the Nicorette Inhalator to all smokers including those who continue to smoke, which supports smoking reduction as the first step to cessation. Smoking cessation is no longer about either quitting or not, but instead should be seen as a continuous process that can involve several stages."

Stephen Foster, Pharmacist, Kent

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McNeil

Nicorette Inhalator Product Information:
Presentation: Inhalation cartridge containing 10mg nicotine for oromucosal use via a mouthpiece. Uses: Relieves and/or prevents craving and nicotine withdrawal symptoms associated with tobacco dependence. It is indicated to aid smokers wishing to quit or reduce prior to quitting, to assist smokers who are unwilling or unable to smoke, and as a safer alternative to smoking for smokers and those around them. It is indicated in pregnant and lactating women making a quit attempt. **Dosage:** ***Adults and Children over 12 years of age:*** Nicorette Inhalator should be used whenever the urge to smoke is felt or to prevent cravings in situations where these are likely to occur. Smokers willing or able to stop smoking immediately should initially replace all their cigarettes with the Inhalator and as soon as they are able, reduce the number of cartridges used until they have stopped completely. Smokers aiming to reduce cigarettes should use the Inhalator, as needed, between smoking episodes to prolong smoke-free intervals and with the intention to reduce smoking as much as possible. As soon as they are ready smokers should aim to quit smoking completely. When making a quit attempt behavioural therapy, advice and support will normally improve the success rate. Those who have quit smoking, but are having difficulty discontinuing their Inhalator are recommended to contact their pharmacist or doctor for advice. **Contraindications:** Children under 12 years and Hypersensitivity. **Precautions:** Unstable cardiovascular disease, diabetes mellitus, G.I disease, uncontrolled hyperthyroidism, phaeochromocytoma, hepatic or renal impairment, chronic throat disease, obstructive lung disease or bronchospastic disease. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and both less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. Best used at room temperature. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Cough, irritation of throat and mouth, headache, nasal congestion, nausea, vomiting, hiccups, palpitations, GI discomfort, dizziness, reversible atrial fibrillation. See SPC for further details. **RRP (ex VAT):** 6-Starter pack £6.64, 42-Refill pack £20.89. **Legal category:** GSL. PL holder: McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **PL number:** 15513/0179. **Date of preparation:** March 2010

Nicorette Gum Product Information.
Presentation: Nicorette 4mg gum and Nicorette 2mg gum contain 4mg and 2mg of nicotine respectively in a chewing gum base. Original, Mint, Freshmint, Freshfruit and Icy White flavours. Uses: Relief of nicotine withdrawal symptoms as an aid to smoking cessation. Used to help smokers ready to stop smoking immediately and also smokers who need to cut down their cigarette use before stopping. **Dosage: Adults (over 18 years):** No more than 15 pieces of gum should be used each day. Use when there is an urge to smoke. Patients smoking 20 or less a day should use 2mg gum. Those smoking more than 20 should use 4mg gum. Each piece should be chewed slowly for about 30 minutes. Smoking cessation: Patients should stop smoking during treatment. After up to 3 months ad libitum dosage, Nicorette gum use should be gradually reduced. Those who use NRT beyond 9 months should consult a healthcare professional. Smoking reduction: Use the gum between smoking episodes to reduce smoking. A quit attempt should be made as soon as the smoker feels ready but no later than 6 months. Professional advice should be sought if no reduction in 6 weeks or no quit attempt in 9 months. **Adolescents (12 to 18 years):** No more than 15 pieces of gum should be used each day. Smoking cessation: After 8 weeks ad libitum dosage, reduce gum use over 4 weeks. If not stopped by 12 weeks, a healthcare professional should be consulted. Smoking reduction: Only after consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Denture wearers, GI disease, unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Transferred dependence is rare and less harmful and easier to break than smoking dependence. May enhance the haemodynamic effects of, and pain response to, adenosine. Keep out of reach and sight of children and dispose of with care. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Headache, sore mouth or throat, jaw-muscle ache, GI discomfort, hiccups, nausea, vomiting, dizziness, erythema, urticaria, palpitations, allergic reactions, reversible atrial fibrillation. See SPC for further details. **RRP (ex VAT):** 2mg gum (10) £2.84, (30) £4.83, (105) £13.23, (210) £22.07; 4mg gum (30) £5.94, (105) £16.12, (210) £27.16. Icy White 2mg gum (30) £5.08, (105) £13.96; 4mg gum (105) £17.09. **Legal category:** GSL. **PL numbers:** Original 2mg 15513/0169, 4mg 15513/0170; Mint 2mg 15513/0171, 4mg 15513/0172; Freshmint 2mg 15513/0173, 4mg 15513/0174; Freshfruit 2mg 15513/0136, 4mg 15513/0137; Icy White 2mg 15513/0152; 4mg 15513/0153. **PL holder:** McNeil Products Ltd, Roxborough Way, Maidenhead, Berkshire, SL6 3UG. **Date of preparation:** March 2010

Update

Your weekly CPD revision guide
Module 1536

End of life care: part 2

The second article in this series covers how to prevent and manage common problems that may develop in patients who are terminally ill

60-second summary

This article, which can be used for your CPD, considers common end of life symptoms other than pain management, which was covered in last week's Update.

What can be done to prevent distressing symptoms?

Risk factors can be identified to prevent certain symptoms developing, eg laxatives should be given with opioids, and use of an anti-emetic should be considered when a strong opioid is first prescribed.

What are the other most common symptoms?

Breathlessness occurs in 70 per cent of cancer patients, becoming severe in 25 per cent in the last week of life. It may be made worse by fear of dying. Low-dose morphine may be useful for patients not already on opioids. Lorazepam is useful in panic attacks, or diazepam or midazolam in the longer term.

Doreen Cochrane MRPharmS

This article explores other common symptoms besides pain (covered in last week's Update, July 17, p16) experienced by patients approaching the end of life. By offering information and advice about symptom management and side effects of treatment, pharmacists can help patients and their carers feel supported and respected during this important phase.

Constipation

Opioids are the most common cause of constipation in patients needing end of life care. They exert this side effect by binding to peripheral receptors in the gastrointestinal tract. The effects of this binding include maintaining or increasing intestinal smooth muscle tone, suppressing forward peristalsis, increasing sphincter tone, increasing fluid absorption and reducing sensitivity to rectal distension. The overall result is the formation of dry, hard stools that are difficult to pass.

Other causes of constipation include the effects of metabolic disturbances (eg hypercalcaemia), the patient's debility, medicines other than opioids (eg antimuscarinics, verapamil) or concurrent disorders. Risk factors for constipation should be identified, and addressed wherever possible, to prevent constipation or faecal impaction developing.

Current guidelines recommend that laxatives should be co-prescribed with opioids to prevent constipation occurring. A combination of a stimulant (eg senna, bisacodyl) and a stool softener (docusate) may be used. An osmotic laxative (lactulose, macrogols) is an alternative option. Frail or nauseated patients may not be able to tolerate the fluid volumes required either to administer the macrogols or to prevent side effects of lactulose.

Patients who have received opioids for two or more weeks and have taken laxatives for three days without effect may be prescribed oxycodone and naloxone combined in a modified-release oral formulation (Targinact). Rectal administration (eg bisacodyl) or a subcutaneous injection (methylnaltrexone) may be used when medicines cannot be taken orally.

Some opioids (eg fentanyl) are associated with a lower incidence of constipation than morphine. When an alternative opioid is prescribed, or the opioid dose is reduced, the laxative dose may need adjustment.

Nausea and vomiting

The cause of these symptoms is often multi-factorial and requires skilled assessment. Opioids are thought to induce nausea and/or vomiting by a direct action on opioid receptors in the chemoreceptor trigger zone (CTZ) in the brain. Stimulation of these receptors results in nausea and vomiting in two-thirds of patients, so the use of anti-emetics must be considered when a strong opioid is first prescribed. Patients who are already experiencing nausea and vomiting from another cause, or who are experiencing or have previously experienced nausea and vomiting from a weak or strong opioid will require an anti-emetic.

The most commonly used treatments are cyclizine and haloperidol, administered orally or parenterally. Levomepromazine is useful for nausea and vomiting of unknown cause. It helps with agitation and so is useful for people with both nausea and agitation. A prokinetic agent (metoclopramide or domperidone) acts by increasing gastric emptying and may be useful in patients with gastric stasis. Cyclizine and other antimuscarinics block the action of metoclopramide, so concomitant use must be avoided.

If nausea and vomiting persist it is important to reassess the patient. Intractable nausea is common in malignant disease and can also be due to autonomic disturbances, medications, gastric stasis or bowel obstruction.

Cachexia, anorexia and fatigue

Cachexia, anorexia and fatigue are an overlapping and sometimes neglected group of symptoms. Cachexia is a complex syndrome that combines weight loss, lipolysis, loss of muscle and visceral protein, anorexia, chronic nausea and weakness. It is more common in patients with solid tumours (with the exception of breast cancer), children and elderly patients and usually becomes more pronounced as the disease progresses.

Several drugs have beneficial effects on symptoms in the short to intermediate term. Medroxyprogesterone and megesterol acetate may improve appetite, calorie intake and nutritional status in patients with advanced cancer. Prednisolone or dexamethasone may improve both anorexia and weakness in cancer patients. Nutritional and pharmacological interventions for weight loss in people with advanced disease are of limited value in arresting or reversing this symptom in the longer term.

For some patients food intake can be improved

by providing small and frequent meals that are fortified with calories. Attention to food presentation, environment and the patient's preferences is important. Macmillan Cancer Support has developed an e-learning module on weight loss and eating (at www.learnzone.macmillan.org.uk), which includes approaches aimed at mitigating the effects of distressing emotions brought on by changes in eating habits. The approach encourages changes in thinking and behaviour to support better self management of weight loss. It helps elucidate some of the more complex emotions, such as loss of control and helplessness, elicited by weight loss and changes in eating for both the patient and carer.

Breathlessness

About 70 per cent of patients with cancer experience dyspnoea in the last few weeks of life and 25 per cent experience severe dyspnoea in the last week. This symptom is usually progressive and can be distressing for both the patient and caregivers. Concurrent diagnoses such as cardiopulmonary failure may exacerbate the problem. Patients with asthma and COPD benefit from inhaled or nebulised medications and, in some cases, oxygen. Furosemide, given orally or intravenously, can help symptoms in patients with heart failure or pulmonary arterial hypertension. Patients with motor neurone disease suffer from breathlessness due to progressive respiratory muscle weakness.

Simple interventions such as opening the window, use of a fan and reassurance may help. A low dose of an immediate-release formulation of morphine (2.5mg) four-hourly when required will generally ease breathlessness in patients not already prescribed an opioid. The mechanism of action is unclear but opioids may reduce respiratory drive and the sensation of respiratory muscle fatigue.

Fear of dying may also contribute to the symptom of breathlessness. Lorazepam 0.5-1mg sublingually gives rapid relief from panic attacks. For longer term use diazepam 2mg at night or twice daily may be prescribed. Midazolam 2.5mg subcutaneously two- to four-hourly when required is particularly useful if the breathlessness is associated with anxiety. Subcutaneous administration may be continued via a syringe driver in the terminal phase.

Last days of life

It can be difficult to predict when a patient is nearing the last few days of life. The recommendation in the Liverpool Care Pathway is for the assessment to be based on the presence of a number of different signs and symptoms. At this stage a written treatment plan is agreed with the patient and caregivers. The plan and prescription chart describe which medicines should be administered in the event of symptom breakthrough or on a continuous basis. Communication with social and healthcare professionals in other services is vital to ensure continuity of care and support to both the patient and carers.

The oral route should be used to administer drugs for as long as possible. However, when this is no longer available, the subcutaneous route offers a safe and effective option for many drugs that are considered critical for the continued care of the patient. Portable infusion devices, usually the Graseby syringe driver, allow continuous infusions of medicines to be administered. The rate of drug administration from the MS26 device is described in mm per 24 hours (daily rate).

An example of a dosing algorithm, showing how a patient could be switched to subcutaneous infusion to manage pain, is available in the full version of this article online at www.chemistanddruggist.co.uk/update. Combinations of two, three or four drugs are commonly given to manage symptoms of pain, nausea and vomiting, terminal agitation and delirium, and respiratory tract secretions. Local palliative care guidelines contain information on suggested dosage ranges and indications for use of drugs via a syringe driver. Such guidelines also contain information about the drug combinations that can be administered, including concentration and stability details for these mixtures.

Nausea and vomiting

For patients already on an effective anti-emetic, this may be switched to the parenteral route. Levomepromazine 6.25mg may be prescribed eight-hourly subcutaneously when required. If two or more doses were required in a 24 hour period a syringe driver may be initiated – the starting dose is usually 12.5-25mg subcutaneously over 24 hours.

Cyclizine is an alternative option. However, if cyclizine is mixed with diamorphine, precipitation occurs at higher drug concentrations so care is needed. Metoclopramide at high doses may cause extrapyramidal symptoms.

Respiratory tract secretions

Noisy respiratory secretions (death rattle) in the last hours of life occur in up to 92 per cent of deaths in a palliative care unit. These symptoms are sometimes very distressing for those caring for the dying person. Non-pharmacological interventions such as repositioning are recommended as a first step. Prompt treatment with hyoscine hydrobromide, hyoscine butylbromide or glycopyrronium bromide is needed to prevent secretions accumulating. Choice of drug may depend on the preferred route of administration, the adverse effects profile of the drugs and drug availability. Hyoscine has a rapid onset of action and it begins to take effect within 15 minutes of subcutaneous administration.

If symptoms are already present, hyoscine butylbromide (Buscopan) 20mg may be administered subcutaneously immediately and 80-120mg via a syringe driver over a 24-hour period. Alternatively, glycopyrronium 200µg may be administered subcutaneously immediately then 600µg over 24 hours. This can be continued at 200µg eight-hourly when required, increasing the total 24-hour dose to 1,200µg after 24 hours if symptoms persist. If symptoms are not present glycopyrronium 200µg eight-hourly may be prescribed for use if required. If two or more doses are used in 24 hours a syringe driver may be started to deliver the drug subcutaneously. With both these drugs the dose should be reviewed every 24 hours.

Agitation and delirium

These symptoms are common in the last days or hours of life. Midazolam is useful if the patient is agitated. Midazolam 2.5mg to 5mg subcutaneously, four-hourly when required, is most often prescribed. The patient should be reviewed after 24 hours and if two or more doses have been used then administration may be continued using a syringe driver. The daily dose of midazolam is the dose required over the previous 24 hours. Additional 'when required' or rescue dosing should be continued. Haloperidol may be used as an alternative, especially if agitation is accompanied by delerium.

Conclusion

Pharmacy team members will have knowledge of the patient's culture, beliefs and relationships, which will help with understanding the patient's needs at the end of life. It is possible to use this knowledge to reach out to patients; in the end the patient's beliefs about death must be respected, and wherever possible their preferences for place of care, to ensure a dignified and good death.
An example of a dosing algorithm is available online at www.chemistanddruggist.co.uk/update

Doreen Cochrane MRPharmS is an independent pharmacist and trainer

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online (p18).

Learning resources

- www.learnzone.macmillan.org.uk
- e-Learning for Healthcare – www.e-lfh.org.uk
- www.leedspalliativecare.co.uk/Resources.aspx
- National Council for Palliative Care – www.ncpc.org.uk

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NEXT UPDATE
The final part of our therapeutic drug monitoring series looks at immunosuppression

End of life care: part 2

Why do opioids cause constipation? What are the most common treatments for nausea and vomiting in end of life care? What is cachexia and how is it treated?

This article describes the management of constipation, nausea and vomiting, breathlessness, fatigue and agitation in end of life care. It includes information about the drugs used and care in the last days of life.

- Read more about the treatment of opioid-induced constipation from the Wyeth Healthcare Professional's Guide at http://tinyurl.com/constipation10.
- Find out more about nausea and vomiting from the Patient UK website at http://tinyurl.com/nausea10.
- More information about cachexia can also be found on the Patient UK website at http://tinyurl.com/cachexia10.
- Read more about the treatment of breathlessness on the CKS website at http://tinyurl.com/breathlessness10. See the controlled breathing leaflet on the Marie Curie Cancer Care website at http://tinyurl.com/breathlessness2.
- For further learning, the CPPE has a programme on Palliative care (ref 37029) at www.cppe.ac.uk.

Are you now familiar with the treatments available for end of life care? Could you use your knowledge of a patient to help with understanding their needs at the end of life?

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Get a CPD log sheet for your portfolio when you successfully complete the 5 Minute Test online.

Practical Approach

What's causing this child's white blotches?

"David, Mrs Webb's outside and she's hopping mad. I think you ought to see her right away," says Brenda, pharmacy technician at the Update Pharmacy, as she goes into pharmacist David Spencer's office.

"OK. You'd better send her in here," David replies.

A few moments later Brenda shows a very angry looking woman into the office, with a boy aged about six trailing behind her. David greets Mrs Webb politely and asks what the problem is.

"I'm going to sue you and report you to your authorities. And the manufacturer and Dr Adi-Varli too," the woman says. "You've harmed my child."

David asks her to explain and Mrs Webb continues: "A couple of weeks ago I got a new moisturising cream on prescription for Justin's eczema, and now he's come out with white blotches over his face.

"My neighbour says that it's something called vitiligo and that it's incurable. And it's this cream that's caused it! "

David replies: "I'm sorry to hear about it. But can I have a look at Justin's face and ask a few questions to try to sort this out?"

Mrs Webb grudgingly agrees. David examines Justin's face and asks him if the patches are sore or itchy, or anything, to which Justin answers no. He then asks Mrs Webb if there are any patches anywhere else. The answer is again no.

"Well," David says, "I'm pretty sure that this is nothing serious, won't last too long and is nothing to do with the cream. But you could ask Dr Adi-Varli if you want a second opinion."

Questions

1. What is this likely to be?
2. What are the clinical features?
3. What is the treatment?
4. What advice could David give?

Answers

1. Pityriasis alba, a condition of unknown aetiology that occurs fairly commonly in children (incidence about 5 per cent) and even more frequently in atopic individuals. It normally resolves spontaneously within a few weeks to about a year. It has no connection with vitiligo. Reported contributory factors include excessive and unprotected sun exposure, poor hygiene, and environmental influences such as temperature, humidity and altitude.
2. The most common locations are on the cheeks, around the mouth and chin. The forehead, neck, shoulders, upper chest, and upper arms can also be affected. Lesions appear as several (two to 20) hypopigmented patches ranging in size from 1-4cm, which may have slight and subtle scale. There may be initial mild pruritic erythema. Patches appear more pronounced on dark or suntanned skin.
3. In most cases no treatment is required. For associated pruritis, emollients may help. For more severe and persistent cases, topical steroids, pimecrolimus or PUVA (psoralen plus ultraviolet light) may be prescribed. Hydrocortisone 1 per cent cream is available OTC, but it is not licensed for use on the face or at all for children aged under 10 years.
4. Keep the skin well moisturised. Use non-soap cleansers or moisturising soaps and apply emollients. Avoid sun exposure and wear sunscreen.

Based on Bassam, Z. Pityriasis alba. e-Medicine Dermatology. 2009. http://emedicine.medscape.com/article/1068868

To get Practical Approach emailed to you every week, sign up to C+D's free CPD bulletin at **www.chemistanddruggist.co.uk/register**

Got an idea for a Practical Approach scenario or would like to write one? Email us at: **haveyoursay@chemistanddruggist.co.uk**

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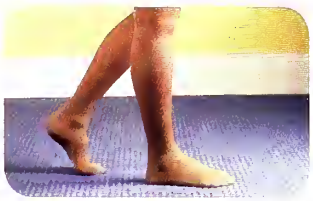

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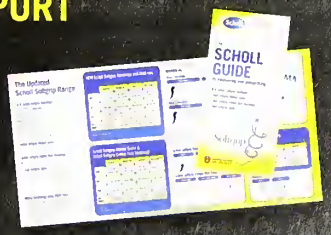

You can also write to us at FREEPOST SCHOLL UK.

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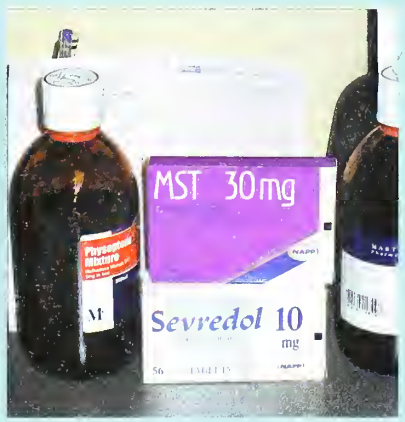
KEEPING BRITAIN ON ITS FEET

ETHICAL DILEMMA

This series aims to help you make the right decisions when confronted by an ethical dilemma. Every month we present a scenario likely to arise in a community pharmacy and ask a practising pharmacist and/or a member of the Pharmacy Law and Ethics Association (PLEA) to comment on the legal and ethical implications of the actions open to you. Readers are invited to have their say at **haveyoursay@chemistanddruggist.co.uk**

Supplying CDs without a legal prescription



The dilemma

You receive a legal prescription from a local surgery on a Friday afternoon. The prescription is for MST but has not been dated. You take it back to the surgery for amendment but are told to return on Monday as the doctor is too busy. The patient, 78-year-old Mr A who is on crutches, comes in for the prescription on Saturday. You know the patient well, he is in obvious pain and says he has run out of tablets. You have a good working relationship with the surgery and are happy that it will be sorted first thing on Monday morning. Do you supply the MST?

Your first consideration should be for the patient's welfare. To tell Mr A that the only legal course of action is to send him to an out-of-hours GP for a legal prescription may not be appropriate, especially considering his mobility problems and pain.

However, a few years ago a pharmacist who supplied MST to a patient (who was terminally ill and died that weekend) received a written warning from the RPSGB because she did not signpost the patient to an out-of-hours surgery.

Ethically, the pharmacist put the patient's welfare first; the patient's pain was controlled, and her last few hours were spent with her family, not in a waiting room. But legally the pharmacist should have signposted the patient.

One solution is to phone the out-of-hours GP, who may be willing to write a prescription. I did this, and fortunately a local GP, who knew both the patient and me, was on duty. He was happy to write a prescription without seeing the patient, a member of staff collected it and the patient received his medication with only minimal delay.

This dilemma can be avoided if, when a CD prescription is received that cannot be legally dispensed, the pharmacy contacts the patient to find out when the medication will run out. This can then be communicated to the surgery to ensure the issue is prioritised accordingly.

Louise Laming MRPharmS is manager of Manor Pharmacy (Wheathampstead) Ltd

The supply being sought by the patient essentially amounts to a request for an emergency supply because there is no lawful prescription to cover it – Regulation 15(1)(a) of the Misuse of Drugs Regulations 2001 requires a prescription for a controlled drug to be dated.

According to regulation 8(2)(d) of the Prescription Only Medicines (Human Use) Order 1997, emergency supplies cannot be made of schedule 1, 2 and 3 controlled drugs; morphine sulphate is a schedule 2 controlled drug.

The supply of morphine sulphate to the patient in these circumstances would therefore be unlawful, by reason of section 58 of the Medicines Act 1968 and the Misuse of Drugs Act 1971.

I have acted for several clients who have been interviewed by police controlled drugs inspectors and/or Royal Pharmaceutical Society inspectors, and against whom both criminal and disciplinary action has been taken where supplies of controlled drugs have been made otherwise than in accordance with a prescription, including in circumstances where the pharmacist thought he/she was acting in the patient's best interests.

While it is difficult for any pharmacist to leave a patient without access to medicines, where schedule 1, 2 or 3 controlled drugs are concerned this may be the pharmacist's only option. This does not, of course, prevent pharmacists from doing all they can to obtain a valid prescription for the patient, as the pharmacist did here.

Noel Wardle is a solicitor at Charles Russell LLP, specialists in pharmacy law.

More dilemmas are online at www.chemistanddruggist.co.uk/ethicaldilemma

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PLEA

PLEA is an association of pharmacists interested in law and ethics, and lawyers or ethicists specialising in pharmacy, with the aim of promoting understanding of the ethical basis for professional judgement **www.wingfieldworks.co.uk/plea/index.html**

Next month's Ethical Dilemma

Should you do 'easy' MURs just to hit your target?

We need more Ethical Dilemmas. If you have an interesting scenario that you can share with your fellow pharmacists, get in touch via haveyoursay@chemistanddruggist.co.uk

Health and wellbeing at work is important for both employees and pharmacy businesses – without healthy happy staff, customer service is likely to suffer. Over the coming months C+D will be giving you guides and tips on improving your wellbeing, covering everything from boosting morale in the dispensary to your legal rights. If there is a health and wellbeing issue you would like us to cover, email jennifer.richardson@ubm.com.

YOUR HEALTH AND WELLBEING AT WORK PART FOUR

Crime in the pharmacy

All pharmacies may be at risk of crime, but with careful planning you can minimise the risks, says **Zoe Smeaton**

The day job might involve a lot of stress, but fighting crime shouldn't have to be on the to-do list as well. If pharmacists are to ensure patients receive their medicines safely and quickly, they need to be free to work in a safe environment. Yet for many pharmacists this reality can feel a long way off.

This year the C+D and PDA Salary Survey found almost one in three pharmacists had been the victim of or a witness to a crime at work in the last year, with common crimes including shoplifting and even knife crime. And the sector is not alone as the British Retail Consortium's latest crime survey shows the number of thefts from shops is increasing and incidents of violence and abuse against shop staff more than doubled in 2009.

The consortium says the risk of violence and abuse should never be regarded as part of the job, and pharmacy leaders agree people working in dispensaries should be safe. If pharmacists and staff fear crime they are likely to be more stressed, which could lead to errors as well as impacting on their own wellbeing. As Alan Ledbrook, national loss prevention manager at Lloydspharmacy, says: "There is undoubtedly an impact on morale if employees do not feel safe within the workplace."

Crime stats

28% Employed pharmacists who have been a victim of or witnessed a crime at work

1/3 Increase in thefts from shops in 2009

22k retail employees suffering threats, physical or verbal attacks in 2009

5% of incidents reported at Lloydspharmacy involve robberies, attempted robberies, physical assault, threatening behaviour or verbal abuse

94% of retail crime incidents involve customer theft

Sources: C+D and PDA Salary Survey 2010 and British Retail Consortium Retail Crime Survey 2009

So what can you do to help protect your pharmacy from crime?

The most commonly reported crime in most pharmacies is shoplifting. Lloydspharmacy says robberies when the offenders may be armed, attempted robbery, physical assault, threatening behaviour and verbal abuse account for only 5 per cent of offences reported in its pharmacies. But all pharmacies are different and Boots pharmacist Angela Chalmers says in her Holloway Road store the most common risk is verbal abuse.

Being prepared is the key to preventing most of these crimes. As Romeo Richards from retail loss prevention company Richards International Group says, shoplifting in particular is a crime of opportunity, but "remove the opportunity and you reduce the possibility".

Employers have a duty to protect their staff from crime, so find out what measures are in place in your pharmacy if you don't already know. Boots, for example, has a compulsory violence and aggression training module along with store security guards and other measures.

Mr Richards says key points are to ensure the pharmacy has policies and procedures for dealing with shoplifting – you could even develop a shoplifter awareness programme. Mimi Lau, director of professional and training services at Numark, says: "Staff should be trained on security matters; what is a security risk, how to react to a crime, who and what to report and so on." There should be an SOP in place for when crimes do occur, and any preventative measures needed.

Mr Richards also suggests retail stores use technology to help – perhaps your pharmacy has CCTV directed at the dispensary or outside. And as Ms Lau agrees: "Technology such as CCTV cameras and panic buttons are useful. When I worked at a pharmacy in Huddersfield the neighbouring shops all had radio walkie talkies, which alerted the shops to suspicious characters, any crime that occurred such as shoplifting etc. They were very effective."

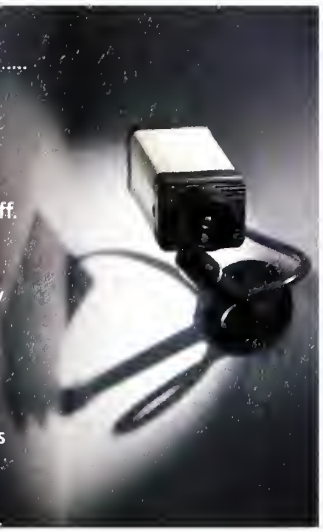
Work with the community

If you're struggling with how to make your pharmacy safer, try looking at other shops in your area, or think about contacting the local police. As Ms Lau says: "Pharmacies should work with local communities for instance, if they are in a parade of shops or part of a wider community. Some towns operate local schemes."

If you can't see any measures in place in your pharmacy and feel you are at risk and need more protection, talk to your employer. They have a legal duty to protect you, and it is in their interests to protect their business and employees. If they don't you can raise the matter confidentially with the government's Health and Safety Executive.

Should you find yourself the victim of crime or being subjected to abuse, Ms Chalmers suggests: "It is best to stay calm so as not to inflame

Crime and Pharmacy



- Retail crime is increasing and one in three pharmacists could have to deal with crime at work.
- Crime can reduce morale and safety.
- Employers have a duty to protect staff.
- There should be SOPs in place for dealing with crimes.
- Staff should all be trained on security measures.
- Consider using technology to help reduce risk of crime.
- Look to other shops for inspiration.
- Get involved in community strategies to reduce crime.
- Report all incidents.

a situation, to keep neutral body language and not to glare directly into people's eyes. Do not block a customer's exit path, as they are then less likely to stay and fight or strike out."

Afterwards you can ask your employer for support if you are affected by the crime, or call charity Pharmacist Support if you need to talk to someone. Numark also offers its members a confidential counselling service through its Choices programme.

Remember it is important to report the crime both to the pharmacy owner and the police. If the crime is related to prescriptions and medicines it may also be relevant to tell your PCT, local GPs or other pharmacies. You could also record significant events on the PMR system to help warn other pharmacists.

And as Ms Chalmers adds: "Briefing the team after incidents so they can all learn how to deal with situations better is also essential." In this way others can learn from your experience, and hopefully you can prevent someone else being a victim of crime in the future.

Employer case study – Lloydspharmacy

All pharmacy employers should have measures in place to protect both their businesses and staff. Alan Ledbrook, national loss prevention manager at Lloydspharmacy, explains the multiple's most innovative tactics.

"Lloydspharmacy has a robust action plan when offences take place that involves not only the loss prevention team, but network operations, and HR.

"We encourage all of our pharmacies to report incidents of crime – if we don't know there is a problem then we can't deal with it. The information supplied feeds into our risk database, which enables the loss prevention team to make decisions regarding security measures needed in pharmacies to minimise the risk to employees. We also encourage employees to report any incidents of a criminal nature to the police.

"Certain measures can be taken to try to minimise the risk of serious offences taking place such as the use of manned guarding, alarm monitoring which enables panic alarms to be installed, CCTV installation, involvement in local police crime initiatives, security mirrors and the provision of training.

"We have also recently begun to install a system called Staff Safe within some pharmacies. This is a 24/7 monitored service that is activated when a member of staff presses a panic button. Once the alarm is activated the monitoring station listens in to what is happening within the pharmacy and, if appropriate, can make a verbal intervention to try and diffuse the situation as well as contact the police. This has proved to be very successful in the pharmacies where it has been installed, and is very popular with employees."

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on crime prevention

REFLECT	Is my pharmacy at risk of crime?
PLAN	Identify ways to make the pharmacy safer and reduce the risk of crime.
ACT	Implement the measures and ensure staff are aware of them.
EVALUATE	Have new measures made staff and patients feel safer?

References

* NHS Blood and Transplant, August 2009: NHS Transplant Activity in the UK, 2008–2009.
† www.kidney.org.uk. June 2010.

I was one of 7190 people waiting for a kidney

5 years waiting

12 hours of dialysis a week

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Dispensing errors: the law and you

What's changed and what hasn't since the Elizabeth Lee case? **Jennifer Richardson** reveals what you need to know now about the criminal prosecution of dispensing errors

Dispensing errors in numbers

- Four dispensing errors (0.02 per cent) and 22 near misses (0.1 per cent) occur for every 22,000 items dispensed in community pharmacies.
- Community pharmacies accounted for less than 0.1 per cent of patient safety incidents reported across all healthcare settings in England, between June 2008 and June 2009.
- 0.7 per cent of patient safety incidents reported by community pharmacies between June 2008 and June 2009 resulted in severe harm – and none resulted in death.

Source: National Patient Safety Agency

Rewind to April last year. Has your confidence in the dispensary taken a dip since then? Are you more risk-averse, less confident about practices such as emergency supplies? And if, in the midst of your innumerable accurate transactions and interventions, you should make a mistake, do you feel less confident about reporting it so that the lessons can be learned by other pharmacists for the greater good of the profession and patients?

If your answers to the above questions are yes, you're not alone. Community pharmacy representatives agree that the spectre of a criminal conviction for a one-off dispensing error has created a "climate of fear" in the sector.

It all started, in the sector's wider consciousness at least, with the now infamous criminal conviction of locum Elizabeth Lee, who in April 2009 was given a suspended three-month jail term for a one-off dispensing error. It prompted an industry-wide campaign, parliamentary meetings, and negotiations between government officials, prosecutors and medicines regulators. Following Ms Lee's appeal success in May (her original conviction was quashed and substituted for a separate offence, and her jail term substituted for a £300 fine), the case is now closed. But the issue it has raised for the sector as a whole is far from settled.

Has the Elizabeth Lee case reduced the risk to pharmacists of a criminal conviction for a one-off dispensing error?

Perhaps a little. The notoriety of the case has caused, pharmacy legal experts believe, a realisation among prosecutors and the judicial system that the heavy-handed approach taken with Ms Lee is counter-productive. And the quashing of Ms Lee's conviction under section 85(5) of the 1968 Medicines Act does set a precedent in case law that only the owner of a pharmacy business can commit a labelling offence. However, as in Ms Lee's case, this can simply be substituted for the section 64 offence of supplying a wrong item to the prejudice of the patient.

Has the case reduced the risk to pharmacists of a jail term if they are convicted of a criminal offence for a dispensing error?

Yes. Pharmacy law expert David Reissner, a partner at Charles Russell, says the prison sentence imposed on Ms Lee was "an aberration", such sentences normally being applied only in manslaughter cases – and the Court of Appeal seemed to agree, calling Mrs Lee's punishment "manifestly excessive". Mr Reissner says: "The appeal court's ruling may help another judge falling into error in a similar case."

What impact has the Crown Prosecution Service's guidance for prosecutors on the issue, released late last month, had?

Not a great deal, unfortunately. Joy Wingfield,

Timeline – the road to decriminalisation of dispensing errors

August 2007
Pharmacist Elizabeth Lee, locuming in a Tesco Pharmacy in Windsor, dispenses propanolol against a prescription for prednisolone. The patient collapses as a result of taking the prednisolone and is admitted to hospital; she recovers from the effects of the dispensing error but later dies from other, natural, causes.

September 2007
Ms Lee is arrested on suspicion of gross negligence manslaughter. She is interviewed, fingerprinted and photographed, a sample of her DNA is taken and her house is searched before she is released on police bail.

June 2008
After attending the police station four times to extend her bail, Ms Lee is formally charged with two counts under the 1968 Medicines Act.

April 2009
After two magistrates' court and two Crown Court hearings, Ms Lee is tried at the Old Bailey, where the judge rules that she was not responsible for the patient's death. Ms Lee changes her not guilty plea to one of guilty in respect of the first charge under section 85(5) of the 1968 Medicines Act (which relates to false labelling) and is sentenced to a three-month suspended jail term. The second charge, under section 64(1) of the Act (which relates to the supply of a medicinal product "not of the nature or quality demanded by the purchaser") is ordered to lie on file.

professor of pharmacy law and ethics at Nottingham University and founder of the Pharmacy Law and Ethics Association (PLEA), says it "misses the point altogether".

Pharmacist representatives had hoped the guidance would direct prosecutors not to prosecute in the case of one-off errors. Instead, it simply restated the factors prosecutors should take (and already be taking) into account when deciding whether or not to prosecute, including public interest. This leaves pharmacists, according to Mr Reissner, "at the whim of prosecutors who will not have the competence to appreciate the relative seriousness or importance of individual dispensing errors". For this reason, pharmacist representatives believe prosecution should not be brought without consultation with the professional regulator which, Mr Reissner says, "should have the understanding of the profession and expertise to weight the gravity of any incident".

How are errors by other healthcare professionals handled by prosecutors?

They're not, usually. Except in the case of manslaughter, errors by healthcare professionals other than pharmacists are not normally a criminal offence. Instead, errors are dealt with by the relevant professional regulator – pharmacist representatives pushing for the decriminalisation of dispensing errors simply argue that pharmacists should have parity with this. Professor Wingfield explains: "Errors involving death of a patient should be considered jointly by the regulator and the Department of Health/CPS first, using the criteria already established for fitness to practise referral; only where there is prima facie evidence of grossly negligent, reckless or intentional commission of an error should a charge of gross negligence manslaughter be considered."

Why is the decriminalisation of dispensing errors in the public interest?

Unsurprisingly, pharmacist representatives agree that the self-reporting of dispensing errors is discouraged by the threat of prosecution – a situation against the public interest. Professor Wingfield says: "In my view, the public interest demands that community pharmacists should be able to report all dispensing errors and possibly near misses to a centralised, anonymous and confidential reporting database without fear of criminal prosecution.

"Full and frank and open reporting is important because only then do you get a chance to analyse trends, frequencies and perhaps identify causes."

Additionally, the threat of prosecution could lead to defensive practice and reluctance to develop novel services, to the detriment of patients. The PDA says it is aware the Lee case has already caused some pharmacists to avoid "more risky" practice such as emergency supplies.

So will one-off dispensing errors ever be decriminalised?

There is still hope. Medicines regulator the MHRA is expected to carry out a full review of the 1968 Medicines Act by 2012; pharmacy legal experts agree amendments to the Act are the only way to fully remove the risk of prosecution to community pharmacists. And two weeks ago the MHRA revealed to C+D that amendments could be fast-tracked ahead of the review, with parliamentary agreement. Mr Reissner points out this will depend on parliamentary time being available; but before his inauguration, new health secretary Andrew Lansley said he would look to change the law within the first year of Parliament. (There is unlikely to be, Mr Reissner notes, any agreement not to prosecute where a dispensing error causes death.)

In the meantime, the Pharmacists' Defence Association (PDA), which represented Ms Lee in her appeal, is "relishing the opportunity to wrestle with the law", according to chairman Mark Koziol, and makes the point that pharmacists should not be prosecuted under the section 64 offence (or, indeed, under the 1968 Medicines Act at all), should the opportunity of another case arise.

How do the above issues affect pharmacy technicians?

A lot. A recent High Court decision made clear that pharmacy technicians face the same risk of prosecution as pharmacists if they supply an incorrect product. Further, the CPS has clarified it is a viable defence for a pharmacist in the event of a dispensing error if (s)he can demonstrate that a pharmacy technician failed to follow the protocol laid down by the responsible pharmacist. Mr Koziol explains: "This creates a perverse incentive for pharmacists to undertake only an initial clinical check and then simply require technicians to work under a protocol that requires them to dispense and check."

What should I do if I make a dispensing error?

There will in the future be a legal duty to report errors, Mr Reissner says. In the meantime, pharmacists have professional responsibilities to report errors – and a failure to do so could lead to professional disciplinary action. However, the PDA stresses that pharmacists should report to a source where their anonymity can be protected. The National Patient Safety Association's National Reporting and Learning System is anonymous and contributes to national learning to improve patient safety. Employers often have their own reporting systems.

The law as it stands

How you can be disciplined for a dispensing error

Under current legal and professional regulations, there are four ways in which pharmacists can find themselves disciplined for a dispensing error:

1. Criminal prosecution – under the Medicines Act 1968 or under manslaughter charges (see below).
2. Professional disciplinary action – by the regulator, currently the RPSGB.
3. NHS terms of service – repeated dispensing errors could be a breach of terms of service, but this is rarely invoked as such cases are more likely to be referred to the professional regulator.
4. Civil proceedings – patients who suffer a dispensing error can sue for compensation.

When a dispensing error could get you a criminal conviction

Under the Medicines Act 1968:

- Section 58 makes it an offence to supply a POM that has not been prescribed.
- Section 64 makes it an offence to supply a wrong item to the prejudice of the patient.

Under manslaughter charges:

- If a dispensing error causes death and is the result of gross negligence, a pharmacist will be guilty of manslaughter.
- If the death is the result of gross negligence, and a pharmacy is owned by a company and there have been systemic errors, the company, any director and the superintendent pharmacist may be guilty of corporate manslaughter.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD on handling errors

REFLECT	Do I know my responsibilities in handling dispensing errors?
PLAN	Consider what I would do if I made a dispensing error.
ACT	Re-read the relevant sections of the Code of Ethics and my employer's policies
EVALUATE	Do I know what procedures to follow if I make a dispensing error?

May 2009
An industry-wide campaign to decriminalise one-off dispensing errors includes an online petition that gains 12,000 signatures of support.

June 2009
England's chief pharmacist Keith Ridge promises a deal with the Crown Prosecution Service (CPS) to protect pharmacists from criminal prosecution for one-off dispensing errors.

March 2010
Coroner's report confirms that Ms Lee's dispensing error did not cause the patient's death.

May 2010
Ms Lee's conviction under the 85(5) offence is quashed by the Court of Appeal and substituted with a conviction under section 64(1). Her jail term is overturned and substituted with a £300 fine.

June 2010
The CPS delivers guidance on the prosecution of dispensing errors but it falls short of pharmacists' expectations and fails to remove the threat of criminal prosecution for one-off mistakes.

July 2010
The MHRA says the door is open to fast-track a change in the law to protect pharmacists against criminal prosecution for one-off dispensing errors, ahead of a planned full review of the 1968 Medicines Act.

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Postscript...

What the Dickens?

The Victorian Pharmacy hit our screens last week, with RPSGB vice-president Nick Barber and cast donning period costume to grind up powders and mix potions at the cutting edge of Victorian science.

The programme was a hit with audiences, pulling in 2.6 million viewers on BBC2. But how did the show rate with our reviewers?

This programme will delight and intrigue many, but was ultimately a tad disappointing. On television today, serious science programmes are a rarity, and there is a large audience for "I'm A Celebrity... Get Me Out of Here" and its ilk, where celebrities and earthworms interact in the name of entertainment. So it was somewhat disappointing that the earthworm ointment was prepared with dried beasties and not the real deal.

> **"It was disappointing that the earthworm ointment was prepared with dried beasties and not the real deal"**

This unfortunately set the tone for the rest of the programme, which was completely sanitised. Even the cold bath treatment was a half-hearted affair. I will watch again, but will probably carry on tutting and proclaiming that my pharmacy practice lecturers (Bath 75-78) would never have let me get away with such shoddy product manufacture.

★★★★★★★★★★

Sandra Gidley, pharmacist and former Liberal Democrat MP

Violet carboys, pestle and mortars and interminable rows of hand-labelled glass bottles, the Victorian Pharmacy certainly looked the part but could it play it?

The Victorians are known for their rather ghoulish tastes and their early remedies were no exception. Cue leeches for blood letting, worms for bruises and the 'everlasting pill': a recycled laxative. All of these were covered in an entertaining and stimulating fashion by professor Nick Barber, domestic historian Ruth Goodman with PhD student Tom Quick, who together will run the pharmacy for four episodes.

Where the programme failed, however, was in its attempt to 'approximate' remedies and 'test' them on volunteers. Victorian remedies included opium, chlorophorm and cannabis. Prof Barber gave his 'patients' 21st century approximations, which while interesting, seemed redundant and left the audience rather confused as to the efficacy of the Victorian pharmacy.

★★★★★★★★★★

Dr Sharmila Chauhan, pharmacist and writer

Dear Sir,

I was delighted to see a colleague of our noble profession don the guise of a Victorian pharmacist and appear on the moving picture box last Thursday.

However, while Mr Barber's efforts showed a healthy mix of enthusiasm and perspiration brought forth by hardy toil, I felt somewhat

> **"I remain convinced my own treatments and remedies are superior"**

discouraged by the substitution of futuristic alternatives. Surely if one desired to regulate the bowels, only the correct formula would produce an authentic result?

While I accept every pharmacist's nostrums differ in form and ingredient, I remain convinced my own treatments and remedies are superior. Now, where did I put my leech jar...

★★★★★★★★★★

The Victorian Pharmacist, C+D's 19th century columnist

@The Web Hunter

In the modern world of publishing, room in print has become scarcer and competition to appear in the printed word has become fierce.

Take this column for example. Last week the Web Hunter was bumped for reactions to our Copperfield column, and the column itself pushed the Victorian Pharmacist back a week.

And with the ability to track exactly how many readers an article gets online, it is easy to gauge just how popular any article or column that C+D publishes is.

Using the laws of supply and demand, from the drugs in short supply in pharmacy to the demand for more patient choice, it is interesting to see from our opinion poll that 57 per cent of our readers (as of Wednesday) would like to see more from Dr Copperfield.

So does this mean that I, the Web Hunter (and also the manager of C+D's online presence), should run a poll to "Save the Web Hunter"? Or should I merely ask: what is it that you would like to read in this column?

In the same way that customer feedback through loyalty schemes or questionnaires helps pharmacy chains do business better, so magazine publishers now have to actively engage with their readers both online and in print.

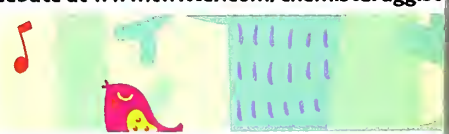
C+D has been somewhat justifiably criticised for this recently, but is making a concerted effort to redress the balance. And as well as this criticism we have started to receive some positive feedback in this regard as well, so we are moving in the right direction.

So if you want us to cover a certain topic - in this column or elsewhere – let us know. You can email us, tweet us, join our Linkedin group (search for Chemist and Druggist) or just give us a call. We would be happy to discuss any ideas you have.

Niall Hunt is C+D's digital content editor; email him at niall.hunt@ubm.com

A social tweet

It was pharmacy week on the telly – join the debate at www.twitter.com/chemistdruggist



@GaryParagpuri: Victorian Pharmacist viewing figures one million above BBC2 average. Still not as good as @ChemistDruggist's Victorian Pharmacist @CandDChris

@CandDHannah: It's pharmacy crazy on TV at the mo, BBC1 had a feature on fake medicines last/n, Ash Soni was on Newsnight and Victorian Pharmacy on Thurs!

Where is the pharmacy industry going?

Tricky question. Simple answer.

Just about anyone who is anyone in the pharmacy business is gathering at The Pharmacy Show this October. There will be more than 220 leading suppliers (the most ever), over 50 world class conference speakers, senior executives, leading regulators, top policy-makers, all the major associations and most importantly of all your industry peers, people just like you... thousands of frontline pharmacists, pharmacy executives, owners and support staff. There's plenty to talk (and learn) about. Whether it's the new frontline healthcare responsibilities facing community pharmacies, strategies and tactics for trading through challenging times or the need to source profitable new retailing ideas, you can get it all at the UK's largest source of world-class, live CPD education and the biggest sourcing event for medicines, equipment, technology, retail and services. And, remarkably, it's all **FREE**.

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Pictured L to R: Bernard Mweseka, Pharmacy Manager, Day Lewis; Dvyesh Patel, Pharmacy Technician, MED-Chem Pharmacy; James Davies, Academic Pharmacist, London School of Pharmacy; Mike Ritson, Superintendent, ABC Drugstores; Richard Harrild, Retail Sales Manager, Lloydspharmacy; Raj Bali, Pharmacist, Lloydspharmacy; Ali Gul Ozbek, Owner-Superintendent, MED-Chem Pharmacy.

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In January 2009 Allen & Hanburys launched Avamys®▼ (fluticasone furoate), an intra-nasal steroid (INS) for treatment of the symptoms of allergic rhinitis.[1] Avamys (fluticasone furoate) is a different chemical entity to Flixonase® (fluticasone propionate) and is therefore a distinct drug molecule and not a salt or a prodrug of fluticasone propionate.[2]

A survey taken in May 2009, amongst 128 pharmacists showed that:[3]

- 31% were unaware of this INS (Avamys, fluticasone furoate).
- 63% were not aware of the differences between fluticasone furoate and fluticasone propionate.

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In a single dose study comparing Avamys to fluticasone propionate nasal spray, patients preferred Avamys over fluticasone propionate based on sensory attributes.[6] Avamys provides relief from both nasal and ocular symptoms in an advanced device.[7-10] Avamys is available to purchase from AAH and Alliance Healthcare.

Prescribing Information
(Please refer to the full Summary of Product Characteristics before prescribing)

Avamys® ▼ Nasal Spray Suspension
(fluticasone furoate 27.5 micrograms/metered spray)
Uses: Treatment of symptoms of allergic rhinitis in adults and children aged 6 years and over. **Dosage and Administration:** For intranasal use only. *Adults:* Two sprays per nostril once daily (total daily dose, 110 micrograms). Once symptoms controlled, use maintenance dose of one spray per nostril once daily (total daily dose, 55 micrograms). Reduce to lowest dose at which effective control of symptoms is maintained. *Children aged 6 to 11 years:* One spray per nostril once daily (total daily dose, 55 micrograms). If patient is not adequately responding, increase daily dose to 110 micrograms (two sprays per nostril, once daily) and reduce back down to 55 microgram daily dose once control is achieved. **Contraindication:** Hypersensitivity to active substance or excipients. **Side Effects:** Systemic effects of nasal corticosteroids may occur, particularly when prescribed at high doses for prolonged periods. *Very common:* epistaxis. Epistaxis was generally mild to moderate, with incidences in adults and adolescents higher in longer-term use (more than 6 weeks). Common: nasal ulceration. *Rare:* hypersensitivity reactions including anaphylaxis, angioedema, rash, and urticaria. **Precautions:** Treatment with higher than recommended doses of nasal corticosteroids may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Caution when prescribing concurrently with other corticosteroids. Growth retardation has been reported in children receiving some nasal corticosteroids at licensed doses. Monitor height of children. Consider referring to a paediatric specialist. May cause irritation of the nasal mucosa. Caution when treating patients with severe liver disease, systemic exposure likely to be increased. Nasal and inhaled corticosteroids may result in the development of glaucoma and/or cataracts. Close monitoring is warranted in patients with a change in vision or with a history of increased intraocular pressure, glaucoma and/or cataracts. **Pregnancy and Lactation:** No adequate data available. Recommended nasal doses result in minimal systemic exposure. It is unknown if fluticasone furoate nasal spray is excreted in breast milk. Only use if the expected benefits to the mother outweigh the possible risks to the foetus or child. **Drug interactions:** Caution is recommended when co-administering with inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole and ritonavir. **Presentation and Basic NHS cost:** Avamys Nasal Spray Suspension: 120 sprays: £6.44 **Marketing Authorisation Number:** EU/1/07/434/003. **Legal category:** POM. **PL holder:** Glaxo Group Ltd, Greenford, Middlesex, UB6 0NN, United Kingdom. **Last date of revision:** January 2010.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to GlaxoSmithKline on 0800 221 441.

Avamys is a registered trademark of the GlaxoSmithKline group of companies.

Prescribing Information
(Please refer to the full Summary of Product Characteristics before prescribing.)

Flixonase® Aqueous Nasal Spray
(fluticasone propionate 50 micrograms/metered spray)
Uses: Prophylaxis and treatment of seasonal allergic and perennial rhinitis in adults and children aged 4 years and over. **Dosage and administration:** For intranasal use only. *Adults:* Two sprays per nostril once daily in the morning. Once symptoms controlled, use maintenance dose of one spray per nostril once daily. Two sprays per nostril twice daily may be required. Maximum daily dose four sprays per nostril. *Children aged 4 to 11 years:* One spray per nostril once daily in the morning. One spray per nostril twice daily may be required. Maximum daily dose two sprays per nostril. For full therapeutic benefit regular usage is essential. The minimum dose should be used at which effective control of symptoms is maintained. **Contra-indication:** Hypersensitivity to any of its ingredients. **Precautions:** Local infections should be appropriately treated. Caution when transferring patients from systemic steroids. Systemic effects of nasal corticosteroids may occur at high doses for prolonged periods. Growth retardation has been reported in children receiving some nasal corticosteroids at licensed doses. Monitor height of children. In addition, consider referring patients to a paediatric specialist. Treatment with higher than recommended doses of nasal corticosteroids may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Avoid concomitant administration of inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole, and ritonavir. **Pregnancy and lactation:** Clinical data is not available. Balance risks against benefits. **Side effects:** Very common: Epistaxis. Common: Headache, unpleasant taste, unpleasant smell, nasal dryness, nasal irritation, throat dryness, throat irritation. Very rare: Cutaneous hypersensitivity reactions, angioedema, bronchospasm, anaphylactic reactions, glaucoma, raised intraocular pressure, cataract, nasal septal perforation. **Presentation and Basic NHS cost:** *Flixonase Aqueous Nasal Spray:* 150 metered sprays - £11.01. **Market Authorisation Number:** PL 10949/0036. **Market Authorisation Holder:** Glaxo Wellcome UK Limited trading as Allen & Hanburys, Stockley Park West, Middlesex, UB11 1BT. **Legal category:** POM. **Date of preparation:** January 2010.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to GlaxoSmithKline on 0800 221 441.

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References
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